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ACCESS TO HEALTH INSURANCE AND HEALTH CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON
INTERGOVERNMENTAL RELATIONS

OF THE

COMMITTEE ON
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

NINETY-NINTH CONGRESS

SECOND SESSION

JUNE 26, 1986

Printed for the use of the Committee on Governmental Affairs

U.S. GOVERNMENT PRINTING OFFICE
62-468 O WASHINGTON : 1986

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

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ACCESS TO HEALTH INSURANCE AND HEALTH CARE

THURSDAY, JUNE 26, 1986

U.S. SENATE,
SUBCOMMITTEE ON INTERGOVERNMENTAL RELATIONS,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:37 a.m., in room SD-342, Dirksen Senate Office Building, Hon. Dave Durenberger (chairman of the subcommittee) presiding.

Present: Senator Durenberger.

OPENING STATEMENT OF SENATOR DURENBERGER

Senator DURENBERGER. Our hearing today examines our ability as a nation to respond to the needs of a group of Americans who are falling between the cracks in the country's health care system.

Their numbers are growing and are now estimated at 37 million, which is up from 33 million at the bottom of the 1982 recession. These 37 million Americans go all or part of every year without something that most of us in this country take for granted, something symbolized by our health insurance card.

Although it seems impossible in this day of artificial heart and organ transplants, 37 million Americans are without the insurance coverage necessary to pay for a broken arm, appendicitis, or the birth of a baby.

Thirty-seven million people represents a population nine times the size of my home State of Minnesota. It is more people than live in the States of New York and California combined.

In Minnesota, a recent survey found that 342,000 people—about the population of the city of Minneapolis—were uninsured for all or part of the year. In depressed rural Minnesota, the problem is much worse—15 percent of the farm families in my State were uninsured for some period of time in 1985.

It is particularly disturbing to me that over 100,000 children in Minnesota are uninsured, and nearly 1 in 5 women between the ages of 18 and 24—those of prime childbearing age—have no medical or hospital insurance coverage whatsoever.

While the effects on these individuals and families of going without insurance are staggering, this critical national problem also has other implications for American society as a whole. We know that the uninsured tend to postpone or go without routine checkups or treatments, often resulting in more serious and more expensive illnesses. Society as a whole thus ends up paying the higher cost of treatment either through tax supported programs, or private insurance.

The estimated 37 million Americans who are uninsured are too young to qualify for Medicare, or they are not poor enough to qualify for Medicaid. Many have existing medical conditions which make them high risk and uninsurable in the private insurance market.

Millions of others are employed part time or on a temporary basis, and are ineligible for employer-paid benefits. Still others are recently laid off and have lost their health insurance benefits. Or, they are self-employed, or working for one of the tens of thousands of small businesses in America that can't afford to offer their employees adequate health insurance benefits.

On May 1 of this year, I introduced S. 2403, the Access to Health Care Act of 1986 with my distinguished colleagues, Senators Kennedy, Heinz, and Riegle. This omnibus offers a set of incremental approaches to the problem of the uninsured.

The bill illustrates the multiplicity of response mechanisms available to finance access for these people: a private sector health provider system; public and private employer financing of health insurance; and local, State, and Federal Government tax policy.

That is why it is particularly appropriate to hold these hearings in the Subcommittee on Intergovernmental Relations. Since I became chairman of this subcommittee in 1981, I have held dozens of hearings that have underscored this simple fact.

Successful policy in public services involves a partnership of Federal, State and local government and the private sector. Health policy is no exception. Therefore, I am pleased we have a balanced group of witnesses today who can help us understand the problem of access to health for the uninsured as well as the implications for intergovernmental relations and the employment sector.

In considering S. 2403, we need to recognize the rising cost of health insurance is a special burden for the self-employed and smaller businesses. These entities are struggling, sometimes unsuccessfully, to provide health coverage to their employees. The last thing we want to do with Federal policy is add any obstacles to coverage. The same is true of local governments and for many States in our Nation. Therefore, we should not set Federal mandates on State or local governments which are unrealistic without sufficient Federal sharing of the cost of these mandates.

[Senator Durenberger's prepared statement follows:]

PREPARED STATEMENT OF SENATOR DURENBERGER

Our hearing today examines our ability as a nation to respond to the needs of a group of people who are falling between the cracks in this country's health care system.

Their numbers are growing and are now estimated at 37 million, up from 33 million at the bottom of the 1982 recession.

These 37 million Americans go all or part of every year without something that most of us in this room take for granted—something symbolized by this little card—health insurance.

Although it seems impossible—in this day of artificial hearts and organ transplants—37 million Americans are without the insurance coverage necessary to pay for a broken arm, appendicitis, or the birth of a baby.

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In depressed rural Minnesota, the problem is much worse. Fifteen percent of the farm families in Minnesota were uninsured for some period of time in 1985.

It's particularly disturbing to me that over 100,000 children in Minnesota are uninsured, and nearly one in five women between the ages of 18 and 24—those of prime childbearing age—have no medical or hospital insurance whatsoever.

While the effects on these individuals and families without insurance are staggering, this critical national problem also has other implications for American society as a whole. Studies have shown that the uninsured tend to postpone or go without routine checkups or treatments, often resulting in more serious—and more expensive—illnesses. Society as a whole ends up paying this higher cost of treatment, either through tax-supported programs or private insurance.

The estimated 37 million Americans who are uninsured are too young to qualify for Medicare or not poor enough to qualify for Medicaid. Many have existing medical conditions which make them high risks and, thus, uninsurable in the private health insurance market. Millions of others are employed part-time or on a temporary basis, and are ineligible for employer-paid benefits. Still others are recently layed off and have lost their health insurance benefits. Or, they are self-employed; or working for one of the thousands of small businesses that can't afford to offer their employees health insurance benefits.

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Large Corporate Exec

1985 Salary and Bonus : $1.6 Million

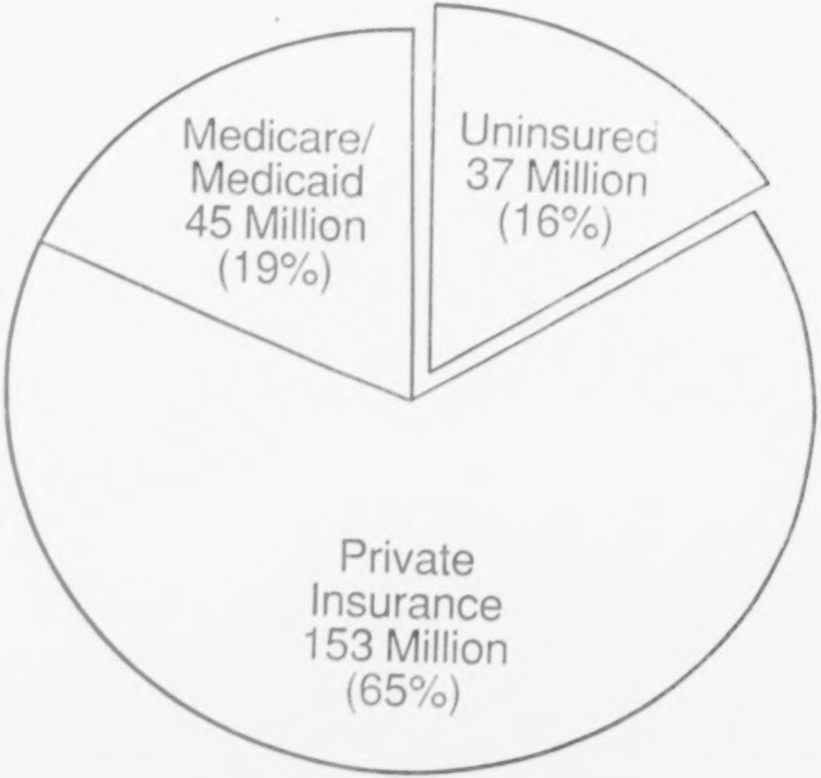
Tax-Free Health Benefits: $3,300

Southern Minnesota Farmer

1985 Taxable Income: $5,487

Tax-Free Health Benefits: 0

Americans Covered by Health Insurance



Senator DURENBERGER. With that, let me call our first witness who is with us today.

Ted, I apologize for arriving late.

Senator Edward M. Kennedy.

Senator KENNEDY. Thank you very much, Mr. Chairman.

If I could, I would like to file my whole statement for the record.

Senator DURENBERGER. It will be made part of the record.

TESTIMONY OF HON. EDWARD M. KENNEDY, U.S. SENATOR FROM THE STATE OF MASSACHUSETTS

Senator KENNEDY. I will summarize it because I know you have a very full and complete agenda for your committee today.

First of all, Mr. Chairman, I want to acknowledge your leadership in this extremely important area, which concerns so many millions of American people. We would not be here this morning unless we had a crisis in health care in two very important areas which you have outlined in the course of your own opening statement, and about which you have spoken to in the introduction of this legislation.

As we have seen by dramatic evidence, in our first chart, the numbers of Americans who are not covered by health insurance has increased dramatically over the period since 1980, from 26 million Americans to over 37 million Americans.

The second chart, Mr. Chairman, points out the extraordinary increase in the amount of charity care that is being provided by community hospitals, moving from $2.8 billion up to $5.7 billion. Right now, an increase of over 100 percent between 1981 and 1984 there is enormous pressure on hospitals all over our country, in the urban areas as well as rural communities, that just cannot afford any additional financial burden in order to meet the challenge of providing charity care.

This enormous pressure on hospitals is a result of the institution of the DRG's and prospective budgeting, and a few more price competitive health care field. Today, there is very little opportunity to transfer resources from those who have decent health insurance over to those that are in need of charity care. Inner-city hospitals and rural hospitals are facing a real crisis: They just cannot provide any additional charity care if they are to remain competitive and financially viable.

Without our legislation, there are going to be millions of Americans whose health is going to be adversely affected because we are just not providing the kind of support these essential institutions need.

With the crisis and the increased numbers of those not covered, plus the charity care, we have this third chart which is, I think, dramatic evidence of what is happening to millions of Americans.

We find that some 4 million Americans who do not even seek needed health care, because they know they cannot afford it, and another 1 million who actually sought care didn't have the ability to pay and were turned away. What we are seeing is a total of 5 million Americans every year will not receive care, but have some kind of health care need. This sad situation has a very dramatic and significant impact in terms of the pain and suffering, and anguish of individual Americans.

So in order to deal with this, Mr. Chairman, we have this four-point program. First, we require employees continued health insurance for a period of 4 months after layoff. We know that 50 percent of those who are unemployed gain new employment do so within the first 4 months. We have been willing as a society to provide some income to those individuals through unemployment compensation for about half a century, continued health care benefits are just as important. Second, if we require States to provide subsidized insurance pools for high-risk individuals. I know the Chair is familiar with the health preconditions which virtually prohibit so many Americans from getting any kind of private health insurance coverage.

Third, we require States to establish a mechanism to fund charity and unreimbursed care provided by hospitals, but we give flexibility to the States as to how to do this. We know that some States are dealing with this at the present time, but we want to make sure that the health institutions are not going to have to depend on whether a particular State has been able to fashion a program. We are going to ensure that these vitally important health institutions are going to be able to provide essential health care to those who cannot pay.

Then our final provision is to try to provide some tax incentive to the small businesses, many of which today are unable to pay the premiums which are necessary to provide health insurance to their employees.

We are very hopeful that in the tax conference that is taking place between the House and Senate, that they will respond to this particular need. It will be in the conference and it can make a major difference for small businesses in our society.

Mr. Chairman, I would hope that we can gain the support for this important legislative proposal. I am very hopeful that we will have the opportunity to include this legislation in the reconciliation bill. I know that reconciliation is still very far down the road, but nonetheless, I hope that we will have the opportunity to deal with this in the reconciliation bill. I think that our legislation will provide some savings at the Federal level, and it provides maximum flexibility to the States. Most important, if the legislation is adopted, it will provide access to essential health care to millions of Americans.

I want to thank the Chair for his interest, and I am very hopeful that we can gain acceptance for this proposal.

[Senator Kennedy's prepared statement follows:]

PREPARED STATEMENT OF SENATOR KENNEDY

I am pleased to have the opportunity to testify on behalf of S. 2403, the Access to Health Care Act of 1986, and its Labor and Human Resources Committee companion bill, S. 2402. These bills embody a bipartisan, four-point initiative to deal with one of the most serious health problems facing the nation—the inaccessibility of health care for millions of our fellow citizens. I would like to thank Senator Durenberger for his leadership in this area and for his work with us and the other principal cosponsors in developing these important proposals.

The crisis in access has two causes and you don't need an EKG or even a stethescope to diagnose them. Too many Americans have no health insurance to pay for care they need. And too many hospitals may soon be forced to shut their doors to those who cannot pay.

Thirty-seven million Americans—one out of every six citizens—have no health insurance at all. Since 1980, the number of persons without such coverage has soared by 42 percent.

At the same time, hospitals face a growing burden in providing care for the seriously ill who cannot pay. Between 1980 and 1984, the cost of hospital charity doubled, from $2.8 billion to $5.7 billion. In the new world of hospital competition, even the most compassionate and committed institutions will soon face a cruel choice between rationing health care for the poor or bankruptcy for their institutions.

According to a recent study sponsored by The Robert Wood Johnson Foundation, one million Americans every year are refused health care because they cannot pay, and an additional four million do not even seek care they need, because they know they cannot afford it.

These bills propose four specific steps to deal with this crisis.

1. HEALTH INSURANCE FOR THE UNEMPLOYED

Employers offering health insurance to their workers will be required to extend coverage for four months after a worker is laid off, as long as the worker agrees to pay the same premium he was paying on the job. In addition, employers will be required to permit open enrollment for family coverage when a worker in a two-worker family is laid off and loses health insurance.

Seventy percent of the unemployed have been without work for less than four months. Because they have lost their employment-based group insurance and can't afford an individual policy, they are forced to go without coverage—and gamble that a medical catastrophe will not strike them or their loved ones.

For half a century, the unemployment insurance system has protected Americans against the income loss arising from short-term unemployment; it is time to provide the same protection against the potentially ruinous cost of a major uninsured illness.

Solving this problem is not a budget-buster. The Congressional Budget Office estimates that as many as 10 million workers and their dependents would benefit from enactment of this proposal. There would be no additional Federal outlays, and the maximum cost to employers would be $1.5 billion, less than seven hundredths of one percent of current payroll.

2. INSURANCE POOLS FOR THE UNINSURABLE

Hundreds of thousands of Americans are not poor but have no access to employment-based insurance and cannot obtain insurance because of their poor health status. Many of these are parents who face the emotional burden of caring for a chronically ill child—a burden that should not be compounded by the fear of financial ruin.

Our proposal requires states to establish pools of comprehensive insurance for all residents, regardless of health status. The pools will be largely self-supporting, but if the premium exceeds 150 percent of the customary cost of individual policies, all employers and insurers offering employment-based health insurance would contribute to the pool. Based on current experience, the cost of the premium subsidy for participating employers will be minimal, between fifty cents and $1.40 per employee per year.

Nine states—Connecticut, Florida, Indiana, Minnesota, Montana, Nebraska, North Dakota, Rhode Island, and Wisconsin—already offer similar pools to their residents; two million Americans could benefit if all states offer them.

Almost all states have mechanisms to provide auto insurance for otherwise uninsurable motorists. Citizens burdened by the cost of serious illness deserve help at least as generous in obtaining the coverage they need.

3. HOSPITAL CARE FOR THE UNINSURED

Charity care for the poor and the uninsured is a traditional mission of community hospitals. For decades, the cost of care for those who cannot pay has been financed out of earnings from paying patients. In today's highly competitive health care system—created in part by government mandated cost controls imposed in recent years—hospitals are increasingly unable to subsidize those who cannot pay. Competition has been an important innovation in the health care system, but it is false economy to deny health care to those who cannot afford it.

Our proposal requires States to establish mechanisms to finance essential hospital care for those who cannot pay. The traditional subsidies that are now drying up must be replaced with explicit help.

New York, New Jersey, and Florida already have such mechanisms in place. Enactment of this proposal will assure that patients with serious illnesses can obtain the care they need. Hospitals must be able to fulfill their traditional mission of care and open their doors to all who need it, free from the fear that bankruptcy will close their doors to all.

4. HEALTH INSURANCE FOR SMALL BUSINESSES

Three-quarters of those without health insurance are workers or dependents of workers—and three quarters of these in turn work for small businesses.

Owner-operators of small unincorporated firms face a significant tax disincentive in providing health insurance for their workers. Employer-paid health insurance premiums do not count as taxable income to the workers, but—because the owner is not an employee—he is not entitled to deduct the cost of his own health insurance as a business expense. Our proposal encourages small businesses to provide insurance to their workers by enabling the owner to deduct the cost of his own personal insurance as a business expense if his workers also participate in the plan. The tax expenditures associated with this proposal would be about $200 million per year as compared to current law and substantially less compared to the Senate tax reform bill.

Small businesses are also less likely to offer health insurance because of higher marketing and administrative costs, which require them to pay 40 to 50 percent more than large firms for comparable coverage. Our proposal requires the Secretary of HHS to conduct studies and demonstrations of methods to reduce the cost of health insurance to small businesses.

Enactment of the measures we are proposing is affordable and achievable within the constraints of the federal budget and the capabilities of the nation's health care system. It will not solve all the problems of the current system, but it will bring decent health care to millions of our fellow Americans who find it out of reach today.

Senator Durenberger. Thank you very much for the testimony, and for your leadership in trying to close that 37 million person gap in a realistic way.

I have a couple of questions. One of the attacks on the bill, if you will, which will be articulated here during the course of this testimony today comes from small businesses. I think we both know what is happening to the cost of employing people in America today, and that that burden is not equally shared between big companies and small companies.

It strikes me, as I have had hearings in my State on this subject, that what is happening to small businesses is that their contributions to payroll taxes, Social Security taxes, unemployment compensation taxes, workers' compensation taxes, are going up constantly, as are the costs of fringe benefits, the premium costs of health insurance over the last 5 or 6 years, pension costs as we make changes in ERISA, and so forth. All of the costs of employing people are going up in this country.

Another thing that seems to be happening to small businesses is that in the competition, particularly for skilled employees, fringe benefits have become a factor in competing for certain kinds of skills. I keep carrying this thing around with me here about the famous executive of an unnamed corporation who has substantial amounts of tax-subsidized free health benefits, and he is competing for skilled workers with some guy in Detroit, Boston, or some small town in Minnesota, with an employer of 100 people or something like that. He is able to offer the folks at this unnamed automobile company $300 a month in health insurance benefits.

I give you that as background which is something, I think, you already know, just for purposes of posing a question about the legitimacy of the argument that the provision in our bill which requires a 4-month extension of health insurance premium will be harmful to small businesses.

What is your view about the cost that that provision is going to add to businesses in America, particularly the small businesses?

Senator KENNEDY. Mr. Chairman, you have put your finger on one of the areas where there is general misunderstanding about our proposal. When this proposal for a 4-month extension average is costed out, we find out that it will add a minimum of approximately 700th of 1 percent to payroll costs. I don't believe there is a business in America that can't afford a burden that is this small.

We have been especially sensitive to the needs of the smallest of the small business companies. We provided a floor of 20 employees in this requirement. Any of the companies that employ less than 20 don't fall under this requirement.

Finally, we continue to allow flexibility in the amounts that would be contributed by the employer and the employee to the overall health plan. I think that given this flexibility, given the fact that we don't require this extension for those companies that employ less than 20, and recognizing the small amount of payroll in terms of total percent of payroll in our society, it seems to me to be a reasonable manageable burden.

I would hope that with these, plus cuts in our proposal and benefits we provide through the tax system, small businesses will be comfortable with this proposal to address one of our most vital health care needs.

Senator DURENBERGER. One of the other objections has been, and I imagine today will be, to the section of the bill that deals with State pooling arrangements for uninsurables. Some people are taking the view that the subsidy for the losses of the pools should be paid for by a broader base, that is maybe by all businesses, or by broad-based tax, or something like that, rather than just be in effect a tax on businesses that provide health insurance. How do you respond to that?

Senator KENNEDY. Mr. Chairman, as you very well remember, when we were looking at this particular proposal, and trying to find out how we could best recommend to the States that they provide some pooling device for the uninsurables, and looking at the additional costs associated with these programs, our best estimate was somewhere between 50 cents and perhaps up to $1.40 per worker per year would be the cost of the business subsidy for these programs.

Senator DURENBERGER. That is on an annual basis, isn't it, somewhere between 50 cents to $1.40?

Senator KENNEDY. That is correct. Once again, when we look at the facts, when we look at the cost, this is not an unreasonable additional burden, particularly when we are talking about the needs of uninsurable individuals all over the country. So I would hope that that issue could be put behind us.

Senator DURENBERGER. Thank you very much for your testimony and your participation this morning.

I understand that Senator Heinz is on his way. Gail Wilensky is here, I think I saw her a little while ago.

Gail, thank you very much for being here. Why don't you come on up. I am sure you won't mind if John walks in, maybe at the conclusion of your testimony, we will let him testify, and then we will get back to questions of you.

Dr. Gail Wilensky is an old friend of ours who has been dealing in the area of health care. She is part of an effort that has been ongoing, Project Hope, with her leadership for some period of time, to deal with the growing problem of providing health care for the indigents, or as it is sometimes called uncompensated care, depending on how you are looking at the problem.

All of us on the policymaking side have a great deal of respect for Gail's insight and intuition, and her ability. We welcome you this morning. Your full statement will be made part of the record. You may proceed.

TESTIMONY OF GAIL R. WILENSKY,[1] PH.D., VICE PRESIDENT DOMESTIC DIVISION AND DIRECTOR, CENTER FOR HEALTH AFFAIRS

Ms. WILENSKY. Thank you.

I am here, as you know, not as a Project Hope representative, although I am vice president of Project Hope, but as an independent health policy analyst. I would like to review quickly some of the problems of the uninsured in our current competitive environment.

As we know, these problems of uncompensated care and the uninsured are not new problems, and the question has been raised as to why they are receiving so much attention. There is some evidence that the numbers have increased, and I will go to that in a minute.

I think that the more important reason for the increased attention is not the increase in the numbers and the amount of uncompensated care, but rather the change in the financial environment of the health care industry.

As you know, we have adopted what we call a "prudent buyer" approach to purchasing health care. That means that people have been concentrating on paying only for what they are purchasing and getting the best price for their purchase. While there are many implications of this shift in the financial environment, the problems of the uninsured and of uncompensated care are the most visible and troubling negative consequences of our move to a more competitive environment.

We know that there has been an increase in the amount of uncompensated care. The numbers of $4 or $5 billion in 1978, $6.2 billion in 1982, $7.8 in 1983, and $9.4 in 1984. The problem, however, is just not uncompensated care, the provider's way of looking at the problem, it is who should pay for those who receive care, but more broadly the problem of the uninsured in a competitive environment.

Measures of uncompensated care understate the problem because they only measure the effects of those who actually gain entry into the system. All of those who are kept out, or keep themselves out, never get to be counted as uncompensated care. We know that this is a substantial portion of the uninsured population.

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[1] See p. 64 for Ms. Wilensky's prepared statement.

Thus, it is not just a question of who pays for the uninsured, but making sure they have reasonable access to care.

In terms of the numbers of the uninsured, there is some dispute today about exactly what those numbers are. As you and Senator Kennedy have indicated, there are some indications, according to the current population survey, some very preliminary and unpublished estimates, that the number may be still increasing and have reached as high as 37 million.

There are some other indications, according to the survey of program and participation, that the number began to decline by mid-1984, declining, in fact, to about 30 million. To me, it makes more sense, given the increase in employment and the decrease in unemployment, even though it has been more in the service sector, that the number probably has been declining since late 1983. But a most important fact to understand is that in our current environment, the uninsured will have great difficulty receiving care.

If there are 30 million uninsured, they will have great difficulty receiving care. It is obviously even a more serious problem if there are 35 or 37 million uninsured.

Despite the difference in estimates of the absolute number of the uninsured, there is great unanimity in the characteristics of the uninsured population. About half of the uninsured appear to be employed either full or part-year. When their dependents are taken into account, about three-quarters of the uninsured population are the employees or their dependents.

While many of these people are poor, in fact, many of them are not poor. At least one-third were in families whose incomes were twice the poverty line, and almost all of the employed uninsured worked for companies that do not offer them insurance coverage, or they are not eligible for insurance coverage.

There are a variety of strategies that can be adopted to reach the uninsured, several of them are reflected in the provisions of the bill which you have introduced. The most direct for reaching the employed uninsured is the provision for unincorporated businesses.

This provision allows unincorporated businesses and self-employed people to use pretax dollars the way the rest of us do. While there is some justification about the equity of this particular way of subsidizing insurance, there is very little justification for excluding this particular segment of the population. While it will not help all of the employed uninsured, it should help both the owners, and with the requirement of the provision to extend insurance coverage to employees, all those employees as well.

There are some other means that could be considered, such as administrative intermediaries and conduits to help with the high administrative costs for small businesses and for high turnover, such as the Health and Welfare Trust concept that unions use.

In addition, there is a provision for the unemployed uninsured. While they are a problem, I would urge you to consider some of procyclical aspects of the particular provision that you have introduced. The concept is an important one, but some of the aspects trouble me.

The uninsurable pool is a very important aspect, and I would applaud that as an introduction. It is especially important that all individuals who are participating, if they be employers, that they not be limited to only those who insure through insurance companies, but to self-insured as well.

The one thing that we cannot do in this competitive environment is do nothing. While I do not agree with all provisions of the bill as it was introduced, there are many aspects that represent important contributions and I applaud your efforts.

Thank you.

Senator DURENBERGER. That was a lot of information in 5 minutes.

As promised, John Heinz is here. John, if you would like to come up now and make your presentation, I think you know Gail Wilensky as well as the rest of us, we will defer whatever questions we have of Gail until you have had an opportunity.

TESTIMONY OF HON. JOHN HEINZ, U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Senator HEINZ. Mr. Chairman, thank you very much.

Mr. Chairman, obviously, I am very pleased to be here and to have the opportunity to speak on behalf of our legislation to improve access to health care. It is going to affect as many as 35 million uninsured Americans. I particularly want to commend you and Senator Kennedy for your leadership in introducing the Access to Health Care Act of 1986, S. 2402 and S. 2403. You are also to be commended for initiating this hearing; it will provide us with a lot of advice.

I am hopeful that the net result of that advice is fast, smooth passage of this legislation into public law. If we do that, I think we will have done well to build upon what is essentially a foundation that Congress laid with your help when we included the Health Insurance Continuation Act in the 1985 Reconciliation bill, COBRA.

I mentioned that there are 35 million Americans who lack health insurance; that is frankly a cold abstraction, and you don't get a very good idea of what that means. What it means in concrete terms is that if you took the 36 largest cities in the United States, they woud be filled with the uninsured, and that is a huge population. Just imagine the 36 largest cities, starting with Los Angeles and New York, and so forth, a huge population daily facing financial risk, devastated by an accident or illness, and that is a population that is growing. Neither age, even income, nor occupation provides much assurance for health care coverage.

The uninsured today includes managers of small businesses who don't have company insurance; unemployed workers who can't afford their own health insurance policy; families with small children suffering from debilitating diseases; early retirees who are too young for Medicare, but too old, too sick, or too poor to obtain private insurance.

As you know, I serve as chairman of the Senate Select Committee on Aging, and I have a particular interest, which is the 3 million people age 55 to 64 who are at risk without any insurance. That group, which you could call the "Pre-Golden Years Group," suffer accelerating health problems. They are not in as good shape as you and me, although you and I are closing in on 55.

We all know how long, expensive, and dangerous, and delibitating it could be for somebody in that age group, 55 to 64, to wait until they turn 65 to be eligible for Medicare.

Let me share with you briefly just two examples from our committee's investigation of people who lacked insurance. One, Beulah S., a widow from San Francisco, testified before our committee last June. She lost her health insurance in 1979 with her husband's death. Within just a few months, she found herself a victim of cancer and, of course, a victim of a health insurance system that shuns risky, high-cost patients. She was too young for Medicare. She was too sick for private insurance. Beulah was forced to use much of her savings to buy the critical medical care that she needed, just about all of her savings, a lifetime's worth.

In another case, Albert J. of Ohio lost his job. His family, of course, lost that health insurance along with it. As luck, so-called, would have it, Mr. J.'s daughter became ill, requiring several hospital stays, and then he, himself, learned that he had cancer.

The findings of our committee, and I have given you two examples, led me to introduce S. 1372, the Health Insurance Availability Act of 1985. It calls for the States to setup pools to sell insurance to high-risk individuals unable to find private coverage, like the two I just named. By also requiring all insuring organizations, including self-insured companies, to participate in the pool or to pay a 10-percent excise tax, the bill circumvents existing restrictions now hampering full use of this valuable coverage.

I think that enactment of legislation like S. 1372 would mean that Americans, maybe as many as 2 million of them, with diseases such as cystic fibrosis, diabetes, and cancer, would be able to obtain the basic passport to health care, and that passport is an insurance card.

Mr. Chairman, I want to thank you for incorporating the substance of my legislation into your, Senator Kennedy's, and also my bill. I think that it will really help in a very major way. It will make risk pool premiums a reality. It will make insurance more affordable. It will make the benefit packages more comprehensive.

I recognize that risk pools for the medically uninsurable provide only a partial response to this problem, but to your credit, your bill takes us a long way to bridging the gap for the 35 million Americans to which I referred. I look forward to working with you, Senator Kennedy, and the House sponsors in the weeks ahead to ensure that your legislation is enacted. I think that it is a major step in making a definitive, tangible commitment to quality care as a right of all Americans, not just of the privileged or lucky few.

Thank you very much.

[Senator Heinz' prepared statement follows:]

PREPARED STATEMENT OF SENATOR HEINZ

Mr. Chairman, I am pleased to have this opportunity today to speak on behalf of legislation to improve access to health care for 35 million uninsured Americans. I also want to commend you and Senator Kennedy for your leadership in introducing the Access to Health Care Act of 1986 (S. 2402/S. 2403) and for initiating this hearing. I am hopeful that this legislation will continue on a fast and smooth journey to public law in this Congress, building upon the foundation laid by Congress when it included health insurance continuation in the 1985 Reconciliation Act (Cobra).

To say 35 million Americans lack health insurance is a cold abstraction, masking the magnitude of the access problem in this nation. What we have, in real terms, are enough Americans to populate the 36 largest cities in this country, daily risking financial devastation from an accident or illness—and their ranks are swelling. Between 1979 and 1983, we saw a 20 percent increase in those lacking the basic protection of health insurance. Economic recession exacerbated this trend, no doubt, but recovery has not stemmed the tide.

Neither age, income nor occupation provides assurance of health coverage. The uninsured today are the managers of small businesses without company insurance. They are unemployed workers who can't afford their own health insurance policy. They are families with small children suffering from dehabilitating diseases. They are early retirees, too young for Medicare but too poor or too sick to obtain private insurance.

As Chairman of the Special Committee on Aging, I am particularly alarmed that almost 3 million people aged 55 to 64 are at risk without insurance. This group, in the "pre-Golden" years, suffer accelerating health problems—and it can be a long and expensive wait until Medicare benefits kick in at age 65.

Let me share with you some examples of Americans at risk for lack of insurance. Beulah S., a widow from San Francisco, testified before the Aging Committee last June. Beulah lost her insurance in 1979, with her husband's death. Within months, she found herself a victim of cancer—and a victim of a health insurance system which shuns the risky, high-cost patient. Too young for Medicare, too sick for private insurance, Beulah was forced to use up much of her savings to buy the critical medical care she needed. In another case, Albert J. of Ohio lost his job and his family's health insurance along with it. As luck has it, Mr. J.'s daugher became ill requiring several hospital stays, and Mr. J., himself, learned that he had cancer.

The Aging Committees findings led me to introduce S. 1372, the Health Insurance Availability Act of 1985, which calls for states to set up pools to sell insurance to "high risk" individuals unable to find private coverage. By requiring all insuring organizations, including self-insured companies, to participate in the pool, or pay a 10 percent excise tax, the bill circumvents existing restrictions now hampering full use of this valuable coverage. Enactment of S. 1372 would mean that as many as two million Americans with diseases such as cystic fibrosis, diabetes, and cancer would be able to obtain the basic passport to health care—an insurance card.

Mr. Chairman, I am especially pleased that you incorporated a modified version of S. 1372 in the Access to Health Care Act. I welcome and support your modifications because I believe that they will help make the risk pool premiums more affordable and the benefit packages more comprehensive.

Risk pools for the medically uninsurable provide only a partial response to the health care access problem. To your credit, the Access to Health Care Act should take us a long way in bridging the gaps in health care coverage by incorporating additional measures to require continued coverage for the unemployed, expand small business coverage, and guarantee hospitals payment for charity care.

The Access to Health Care Act underscores our commitment to quality health care as a right of all Americans—not a privilege just for the lucky few. I look forward to working with you and Senator Kennedy and the House sponsors in the weeks ahead to ensure that this legislation is enacted.

Senator **Durenberger**. John, thank you very much.

I don't know if you have the answers to these questions readily available, but I have a couple or three related questions on the State pool.

There are currently 10, I believe, pools in existence. One of the questions that has been asked of me is "Why do we need this Federal legislation if they are coming along anyway?" A related question is: What would you estimate to be the cost to the States of the risk pool provision; and then have you any notion about the number of people who might benefit from the State health insurance pools?

Senator **Heinz**. Let me take a crack at those, Mr. Chairman. You are right, there are, to the best of my knowledge, only 10 States. The glass is either 20-percent full, or 80-percent empty. In my view, it is 80-percent empty among the 50 States. I think there are some reasons why the other 40 States haven't done much of anything, and that is that there are some ERISA limitations that act as a major problem and disincentive to the States in bringing the self-insured employers into their risk pool programs.

Your bill, as modified, and my bill would solve that problem by the method of the excise tax. It is a forcing mechanism.

You ask how much would all of this cost the State, and is cost an issue for the States. There would be no direct cost to the States. The programs should be designed to be self-sufficient. The self-sufficiency comes from the premiums paid by those who insure, and the assessments paid by the State's health insurance providers.

The only way that there could be a cost to the States might be an administrative cost. In addition, to the extent that the State provided, and most States do, a health insurance program for their employees, they would be assessed some additional amount for participation on the overall risk pool. They wouldn't have to put up a chunk of general revenue to finance the program.

How many people? I think that it is inherently difficult to estimate that. We estimated between 1 and 2 million. What we know is that the 1984 current population survey shows that there are 13 million, about 37 percent of the medically uninsured, that have incomes of at least twice the poverty level, so they could afford, we think, to participate in paying at a reasonable rate for their health insurance. In addition, not all of the 13 million have preexisting health conditions, but we can estimate conservatively a substantial fraction of them do and that is how we get to the 1 or 2 million.

Senator DURENBERGER. Thank you very much, we appreciate your testimony and your leadership in getting us involved in these areas, John. Thank you.

Gail, can I transit from Senator Heinz's comment on the risk pools and their impact to a related part of your testimony on risk pools?

I take it, while the response is that there is no direct cost to the States, but there might be some administrative costs and so forth, there has to be some benefit in this to some element of the State, whether it is a separate program where States put statewide collected money into public hospitals at the local level, or whatever.

There must be an offsetting benefit to States and local governments in particular, or to institutions like hospitals that are in one way or another supported by taxes, or the 501(c)(3) exemption for contributions.

I guess the question I am asking you is, In terms of efficient use of public moneys just for the 2 million people or so who would be involved, the difficult to insure and the uninsurable, and so forth, would it be your view that accessing them through health plans versus the current way we do it is more equitable? What might be some of the benefits?

Ms. WILENSKY. I would definitely prefer the insurance mechanism that you are suggesting here, and I would agree with the number, at least as I have understood the problem, 1 to 2 million is about the number that insurance executives that I have spoken to have suggested as the medically uninsurable.

The advantage in doing this is that the State, by helping to organize the insurance pool, can help put together and manage airtight packages. They can clear the packages which are being offered to these people who are going to be high medical users, just by their very nature, and most efficient, directed, and managed care types of package.

The main benefit to the State is that these are individuals who, by their nature, are going to have high needs of medical care. They now get into the system, or don't get into the system, in a very haphazard way. It will increase the likelihood of these individuals, small but as in many areas of health care, accounting for disproportionate amounts of dollars, to get more directly into the health care system.

I think that it is a far preferable way than to have a grant to providers of certain kinds, be they the public hospital or certain hospitals. That is a mechanism, I think, that is useful for a residual part of the population. When we go, as this bill does, and we aim for the medically uninsurable, when we try to reach as many of the employed uninsured, and perhaps even the unemployed uninsured, we are still going to find that there is a residual, not trivial, population of people who are out of the labor force, who are poor, who do not qualify for any of our public programs. We will need to make some provision for these individuals, and that is the group that, if there is going to be a pooling kind of mechanism that is encouraged in the legislation, it will be directed to that group, although I heartily applaud the language that suggests that there are other ways, such as insurance mechanisms, and that the provision is mainly one of exhortation to the State that you can't forget this population. But for the medically uninsurable, I think insurance is the much better route.

Senator DURENBERGER. Now let me go on the other side. If we come to the conclusion that it is going to save us all money, whether we are big employers, small employers, big taxpayers, small taxpayers, whatever. We are going to save money using the insurance system. Then what about the equities, as to who pays the costs.

Ms. WILENSKY. I am not sure it would save us money or not. To the extent that some of these people are being kept out of the system, even though they are very ill, it is, of course, possible that their will be an aggregate increase to some extent in total expenditures.

Senator DURENBERGER. What is happening to these people, do they just die without ever getting hospital care?

My presumption was that they get very, very ill, and then they come in and they are very, very expensive. Whereas if you had gotten them in a little earlier, they would not have been that kind of an expense, or is that not the case?

Ms. WILENSKY. There is some indication that uninsured people, even when they are sick, when they are compared to insured people, use about half of the health services of the insured population who are comparably sick. Some of the insured population may be overutilizing services. But a 2-to-1 ratio is a very big ratio, and the sense of people who look at this problem is that there is some underutilization among the sick uninsured. The assumption that they get in somehow when they need to, or at the very end, may be more optimistic than we are entitled to.

If we gain access for these individuals, there may be some increase. If we gear the access through managed care, or some directed means, it will be a minimal amount of increase. What it will do is have a more directed means of financing.

As you know, we have just gotten through an implicitly financed system where those who got in without health insurance had their costs passed through to the privately insured population. What this bill does, with regard to the medically uninsurable, is explicitly put it on the employers. It puts it on all employers, and not just those who insure through regular insurance means.

Senator **Durenberger**. We are also covering the self-insured.

Ms. **Wilensky**. You are covering the self-insured, which is a very good provision. The only concern I have is whether there are any potential negative aspects for the United States with regard to international competition. When you place it on employers, instead of using an income tax or a general tax not related specifically to employment, you get away from that risk. The provision you have, though, is broad-based, and it has the very important feature that it does not let the employers who are self-insured escape from being contributors.

Senator **Durenberger**. One of the problems we are going to hear about today is the discrimination on the basis of cost per worker between big employers and small employers.

Ms. **Wilensky**. That is a little bit more difficult question. Part of the reason, as I understand it, that big employers pay such small administrative costs in their insurance is not a risk pooling concept, but rather that the employer picks up many of the administrative expenses that the small employer is not able to. That is, there is only one transaction between the big corporation and the insurance company, and the corporation absorbs all of the administrative costs of dealing with the individual billing. It allows the insurance company to offer a lower rate.

This is an area in which I think States might consider assisting small employers in picking up some of these administrative costs, as well as trying to make some provisions for high labor turnover firms. If the State would set up an administrative intermediary that would mimic the health and welfare trust that unions have set up, it would also help the high labor turnover firms that are unionized, such as restaurants and construction firms.

There may be mechanisms at the State that it may be all right for the Federal Government to make some contributions to, to lower some of these administrative costs.

Senator **Durenberger**. Would you advise us with regard to the State pooling provision to let each of the States decide how they are going to set the "who pays" issue, in other words, are they going to use a broad-based tax, or an excise tax, or a premium tax, or something else? Should we leave that to each State to decide?

Ms. **Wilensky**. I think that you should not only allow that portion, but how they pay the money out. What is best for a State will differ. Whether the State would prefer to use a broad-based financing, or a specific levy, will differ across States. Whether the States see that it is more appropriate to have grants to public hospitals, or to expand their Medicaid, or to include an insurance mechanism for their non-Medicaid eligible population will be different for Pennsylvania and Minnesota, and southern States.

They need to address the problem, and they need money to address the problem, theirs or somebody else's, but exactly the best mechanism, I strongly believe that will differ from State to State.

Senator DURENBERGER. Then the Federal Government contributes to that decision and may even influence that decision in some way depending upon particularly, I suppose, income tax treatment for premiums, for cost-sharing, deductibles, copayments, and for State and local taxes.

So, even though we may not be putting money directly into these pools or into some of the other arrangements, the Nation as such is trying to level off the costs, and make these insurance plans more affordable by enabling employers to deduct the expense, and not have the tax be taxable to the employer or some other mechanism; is that not correct?

Ms. WILENSKY. As you know, I very much favor that. The earlier legislation that you have introduced, S. 2484, along with the other two bills, that would extend the ability to use pretax dollars to all individuals who are not offered employment related insurance, again, on the assumption that if we can extend these individuals the right to use pretax dollars, we increase the likelihood that they will in fact be insured, and we have a more equitale treatment across individuals.

Absent of that, the provision of this bill goes a long way to making some of those provisions available.

Senator DURENBERGER. You are referring to unnamed corporate executive over here, large corporate exec, I don't know how large he is—the basic inequity between large corporate exec and a southern Minnesota farmer, or southern Virginia tool and die maker, or whatever the case may be.

There is a very substantial difference in the Federal tax subsidy to Chrysler and the nonexistent tax subsidy to the small family business. If they are at zero, there is no subsidy. If anything they pay for their health insurance is after tax dollars, there is no subsidy. The only subsidy comes if they spend more than 5 percent of their adjusted gross income, and have enough income to take a deduction.

In that area, there is a potential for us, if we want to help small employers and self-employed people, then we will continue on the path that we just started on in the new tax bill. It is peanuts compared to what we need to do, but at least now we have half the premiums deductible for the self-employed. If we had another $14 billion somewhere, which we wanted to get from large corporate exec, but couldn't because the Health Insurance Association of America objects to doing that sort of thing, we could have made all health insurance premiums deductible for self-employed people.

That would be one of the ways that we could go if we believe that buying insurance at the workplace is the most efficient, and the least expensive way to go about it. One of the ways that we, as a nation, could pay for it is by bringing the subsidies a little bit closer together.

Regardless, I am sure that there will be States that will say: "You are not giving us enough money. If you want us to have pools, why don't you give us the money." The reality is we are already subsidizing the pools, or all of the purchases of insurance, through various deductions.

I have other questions, but I am going to have to submit them to you in writing, and ask for your response. I appreciate very much your coming today.

Ms. **Wilensky**. Thank you very much.

Senator **Durenberger**. Our next witnesses are on a panel, Mr. Aaron K. Trippler, national legislative public relations director, Communicating for Agriculture; Mr. John F. Troy, vice president, Employee Benefits Division at Traveler's; Mr. Andrew P. Czajkowski, who is president of Blue Cross/Blue Shield of Minnesota.

Gentlemen, thank you very much for being here. We will start with Aaron Trippler. Your testimony will be made part of the record.

TESTIMONY OF AARON K. TRIPPLER,[1] NATIONAL LEGISLATIVE PUBLIC RELATIONS DIRECTOR, COMMUNICATING FOR AGRICULTURE

Mr. **Trippler**. Thank you, Senator Durenberger.

My name is Aaron Trippler, and I am national legislative public relations director for Communicating for Agriculture. Our national headquarters is located in Minnesota, and we are very proud of that fact, since the Senator is from Minnesota.

We thank you for the opportunity to appear here today, and for your concern for the uninsurable. Communicating for Agriculture has been involved in this issue much longer than other organizations might believe. Back in 1975, this was the first resolution adopted by our nationwide membership, the fact that we believe in health care concerns of rural Americans, and every person in this country should have the opportunity to purchase health insurance regardless of age or physical condition and at a reasonable cost.

We worked in 1975 to help create one of the first health insurance pools. Connecticut created theirs just prior to Minnesota, but we worked in Minnesota to create the first health pool for the uninsured in the Midwest.

Since 1975, Communicating for Agriculture has followed this issue throughout the country. As you know, 10 States have the health pools in effect right now. We were successful in 1985 in creating the pools in the States of Nebraska and Montana, and in 1986, we have created the pools in Iowa and Tennessee. These pools are not yet operational, but should be within the next 12 to 24 months.

What I would like to convey to you is what we have been hearing, having testified on this issue in 30 States in the last 3 years. We are hearing a lot of concerns about the uninsured, about the cost factors. We believe the No. 1 reason why more pools have not been created is because of the ERISA problem. I don't think there is any doubt in our minds that is the No. 1 concern in the States considering this legislation.

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[1] See p. 77 for Mr. Trippler's prepared statement.

We do have a concern so far as the mechanism proposed here. If you place a tax on the self-insurers, should that money go back to States or should it go to the Federal Government?

We are also finding out that the reason pools haven't passed in more States is a lack of additional models available. I don't believe that we have located the correct alternative to use in a State like California or New York. What works in Minnesota, Nebraska, Connecticut, Florida might not work in California or New York. We are attempting to devise new alternative proposals.

Another concern is the premium cost. As you know, the premiums for pools are set by taking the average cost of premiums of the five largest insurers in that State and raising these premiums by approximately 25 to 50 percent. This creates an undue burden.

For example, in 1984, the State of Wisconsin conducted a survey of participants using the pool. They found nearly 50 percent of the participants in Wisconsin made less than $12,000 a year, and yet the premiums in Wisconsin could range as high as $2,300.

What you are seeing there is the fact that some peopole could be paying a quarter of their gross income to buy health insurance. Wisconsin has now taken a new step, they have created a subsidy level to help those people making less than $16,500 a year. It is working very, very effectively.

Senator DURENBERGER. How do they subsidize it?

Mr. TRIPPLER. They use their State income tax forms, or whatever they file for property assessment, to determine income level. Then they have five categories of subsidy, 6 percent, 12, 18, 24, and 30 percent in subsidy levels. They kicked in $445,000 of State revenue for a 2-year program and haven't even used it all yet, but they feel it is a very good program.

However, we don't believe it is costing as much money as everyone says to run a pool. I know some insurance companies are going to argue with us on that.

Most States provide a credit to those insurance companies for what they are assessed. Therefore, the only cost they are kicking in is the investment income they are losing for that year. It is still a burden, and that is why the self-insurance problems must be changed.

I also want to pass along an answer to a question asked a lot, and that is are the States really kicking in this cost or are they breaking even?

If you take a look at the uncompensated care cost, there really is no such thing as uncompensated care. We are all paying it in the long run. When a person goes to the hospital and does not have health insurance, that cost is usually passed on to those who have health insurance. Therefore, the average premium will go up in the State, and in turn raise the premium for health insurance pools. It all comes back to the same source.

Take, for instance, an individual working for the State of Minnesota. He works in public relations, and he makes $15,000 to $20,000 a year, but wants to start his own firm. Maybe he has not done so, which would have created a new tax revenue source for that State, because he couldn't buy health insurance. In Minnesota, he can because of the pool. But in other States, maybe they haven't looked for new jobs simply because of the threat of not having health insurance coverage.

We have followed this issue for many years. We have testified on it in over 30 States in the last 3 years. There is a need for health pools.

We also want to commend you on your efforts to help rural Americans with their tax deductibility for health insurance premiums, a resolution we have long supported. You have been a very strong supporter of our organization and rural America. We want to thank you, and we are willing to answer any questions you might have.

Senator **Durenberger**. Thank you very much for your testimony.

John Troy from Travelers, and I neglected to say that you are testifying on behalf of the Health Insurance Association of America. Thank you very much for being here.

Mr. **Troy**. Thank you, Mr. Chairman.

With me is Jim Dorsch, who is Washington counsel for HIAA. Mr. Chairman, we have submitted a statement [1] for the record.

Senator **Durenberger**. It will be made part of the record.

TESTIMONY OF JOHN F. TROY, VICE PRESIDENT, EMPLOYEE BENEFITS DIVISION, THE TRAVELERS INSURANCE CO., ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, ACCOMPANIED BY JAMES A. DORSCH, WASHINGTON COUNSEL

Mr. **Troy**. I will be brief, especially in view of all the remarks that have been made this morning.

The health insurance industry has supported the concept of State pools for uninsurables for many years. Representatives of Travelers, Aetna, Cigna, and other companies in Connecticut worked with the legislature there to develop the first pool program in 1975. Travelers administers that program, and I have served as president of the Connecticut association since that time.

Senator **Durenberger**. Since the beginning of the program?

Mr. **Troy**. Since the beginning, yes.

I also serve with Andy Czajkowski, or have served with Andy Czajkowski, on the board of the uninsurables pool in Minnesota, and I am still a member. That is a very successful program, as you know, Senator.

These organizations have a limited purpose, but one which is very important, to provide health insurance availability for persons who can't obtain insurance because of the condition of their health.

A number of years ago, in connection with HIAA's efforts to develop a proposal to deal with all gaps in coverages, we estimated that, due to the breadth of private health insurance, uninsurable pools would not cover more than one-half of 1 percent of the population, and I think that this ties in with the 1 to 2 million figures that were presented here this morning.

Of course, if you are one of that small group of people who might need this coverage, it is obviously very important. The people who do become covered by these pools are high users of medical care. The premiums allowed to be charged, even though higher than the premiums for standard risks, do not cover the cost of the programs.

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[1] See p. 133 for Mr. Troy's prepared statement.

Due to the variety of financing mechanisms for health benefits in this country, it is very important that all financing mechanisms share in the losses produced by covering these high risk individuals. When the losses are properly spread, the impact on any one financing mechanism should be quite manageable.

For example, the Minnesota pool experience spread over all covered people in Minnesota would amount to about $1.40 per person per year; as has been mentioned this morning.

Senator DURENBERGER. Do you know how many persons are covered in that pool?

Mr. TROY. 10,000, Senator. In the Connecticut pool, the costs would be about 50 cents per Connecticut-covered person per year. These is less of a deficit in the Connecticut operation.

The reason for this legislation is, in part, as has been mentioned this morning, because interpretations of prior Federal legislation, ERISA, preclude States from establishing pools which spread the risk over all financing mechanisms. This proposal requires no Federal expenditures, and HIAA urges your support for the uninsurable pools provisions of S. 2403 and S. 1372.

Mr. Chairman, I would like to comment briefly on the other major sections of the Access to Health Care Act. The provisions which would require employers to continue payment for health insurance coverage for terminated employees for a period of 4 months require thoughtful consideration. This requirement would come into effect at a time when an employer may be least able to afford the extra burden of covering terminated employees.

It is quite possible that with some additional changes in the tax law, prefunding of these kinds of benefits may be feasible. We suggest continued study of this aspect of the proposal.

As you know, we are currently implementing the Federal continuation of benefit provisions under COBRA. The superimposition of Federal requirements on existing State legislation is causing an immense amount of confusion not only for the private sector, but for the Federal drafters of regulations as well.

It will be important that any Federal legislation which imposes insurance requirements on the private sector carefully consider the interaction of Federal laws with State laws, and override State laws if necessary.

Finally, we are convinced that as the American health care system moves to a more competitive approach, the issue of uncompensated care must be dealt with decisively. State pools that redistribute hospital revenue to needy institutions have been established in five States, and seem to be working.

Currently there are at least 15 trade associations and consulting firms studying this problem. There is general agreement that the solution must be a broad-based partnership between government and the private sector. We feel that this subject needs a little more study at this time.

Mr. Chairman, if there is any help that the HIAA or any of the individual companies can give in connection with any of the proposals in this bill, I hope that you will call on us. We have added to our copy of the statement a copy of the statement of the Coalition for Health Care Availability.

Thank you.

Senator DURENBERGER. Thank you very much.

Andy.

TESTIMONY OF ANDREW P. CZAJKOWSKI,[1] PRESIDENT, BLUE CROSS/BLUE SHIELD OF MINNESOTA, ON BEHALF OF THE BLUE CROSS/BLUE SHIELD ASSOCIATION

Mr. CZAJKOWSKI. Thank you.

I am Andy Czajkowski, president of Blue Cross & Blue Shield of Minnesota, and I am here representing the Blue Cross & Blue Shield Association, Senator.

I was one of the founders and served as president of the Minnesota pool from 1976 to 1983. I thought that I would give you the benefit of a little bit of experience in that pool because I think that it may be pertinent to the discussions.

We support the idea of encouraging coverage for uninsurable people. Blue Cross plans in many States have provided this coverage for many years. We know that this has been an important part of our operation.

After the legislation was enacted in Minnesota, there was litigation to have the law overturned. A number of insurance companies opposed it, and the law was upheld following appeal to the Eighth Circuit Court.

I think there is concern, however, regarding the self-insurers. There was litigation in Minnesota that determined that ERISA did preempt the State law, and therefore the self-insurers were exempted from participation. We think that the part of your bill that gives the States the opportunity to include the self-insurers is a good idea.

There are about 10,000 people covered in the Minnesota pool. It was originally estimated that there would be about 200,000 people. During the first 5 years, there were less than 2,000 people covered, even though the pool was well advertised, and insurers were required to notify rejected applicants of the coverage.

There hasn't been a great deal of activity. The losses for the pool last year were $5,507,000. Interestingly, of the total claims paid, over 25 percent of the claims are recovered because these people had other coverage. So that gives you an idea that a number of people are in the pool and actually have other coverage available to them.

The magnitude of the problem is not as great as one might perceive. The feeling of the Blue Cross & Blue Shield Association is that there is not a need to mandate these pools for all States. States do have the ability to set up these pools, and they should have the ability to include the self-insurers in the pools, and that we would support.

Since many Blue Cross & Blue Shield plans do make available coverage to uninsurable people within a number of States, there may not be the need of that program in those States.

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[1] See p. 142 for Mr. Czajkowski's prepared statement.

That basically would conclude my testimony. Thank you.

Senator DURENBERGER. Thank you.

Let me ask you, John, or you, Andy, why the difference between the 50 cents per worker per year in Connecticut and the $1.40 in Minnesota?

Mr. TROY. In Minnesota, in order to get in the pool, you have to be rejected for coverage, regular standard insurance coverage, whereas in Connecticut, which is similar to the pool that is set up in your legislation, there is a premium rate established that is above the standard rate, but anybody can come into the pool.

Senator DURENBERGER. They have a tougher population in Minnesta than you have in Connecticut.

Mr. TROY. We think that from time to time some healthy people have sneaked into the Connecticut pool.

Senator DURENBERGER. That is what Blue Cross & Blue Shield of America fears, that there will be too many people getting into the pool, and pretty soon Blue Cross & Blue Shield will lose its claim that it is taking care of all of these uninsured, so it needs the 501(c)(3) exemption; right?

Mr. CZAJKOWSKI. That is one of our agruments. It is not our argument in Minnesota, but we think that there are a lot of other reasons why plans should be exempt besides providing coverage for uninsurables, and I would be happy to go into those. Maybe it is not necessary today.

I think the feeling is that States should not be forced into this if there are other options that may be available to them such as where private insurers are providing the coverage, or Blue Cross plans, or whatever. The magnitude of the problem is really not that great.

I believe in the pool myself, it works well in Minnesota. I am certainly not opposed to it, but I don't know that we need to necessarily mandate it, but rather to encourage the States to adopt some sort of program.

Senator DURENBERGER. Let me ask you all a question about the concerns of small business people which will be articulated later today, and have been in volume for many of us who are the authors of the bill, the great financial burden of extending insurance coverage to laid off workers for up to 4 months.

I think, John, you said that we ought to kind of go slow on that one and study the impact. I have the impression, maybe it is in large corporate executive firms, and other places like that, the unions have bargained in some kind of continuity provision a long time ago for the autoworkers, the steelworkers. We have a precedent out there for longer than 4 months, some of them are at least 1 year, I guess.

Can any of you tell us, on the basis of those experiences, whether the concerns that this would be a large financial burden are realistic concerns or not?

Mr. TROY. I think that the attitude of the insurance companies is that we are hard pressed to sit here and say that the employers should have a burden added to them, since it is not a burden that falls on us.

We try to participate in this process by coming up with different types of solutions. One thing that has been talked about is allowing some other way, maybe allowing a tax break to prefund these benefits. The prefunding area has been cut back.

I do think that in a given situation, with respect to any one employer who has a slowdown in business and a major cutback, it could be a pretty big impact. Some employers already have a very high ratio of nonactive employees to the total employees that are covered under those plans and that, of course, hurts the cost of goods sold from the current business.

I think that in many cases with respect to union bargained plans, or some regular employer plans, this issue is really already taken care of, but there are certain employers where it isn't, and this could fall harshly on them.

Senator **DURENBERGER**. I guess I can understand that—what I don't understand is how the insurance system works. I don't know how many auto workers have been laid off in America, but tens of thousands, maybe hundreds of thousands of auto workers have been laid off in America in the early part of the 1980's, and there must be huge requirements. Is there no learning experience from that about what the requirements would be?

Mr. **CZAJKOWSKI**. Minnesota has, for many years, had a law, prior to this recent Federal legislation, that required extension of coverage for people following termination under the group plan on a self-pay basis. This has been in effect for probably 8 or 9 years, and it is used quite frequently. A number of people do take that coverage, and basically it provides coverage during transition when they would go on to other employment.

The other thing is that even where people become unemployed, often their spouses are working so that they can come under the spouse's program We see a lot of that occurring as well. So there isn't a large number of people who fall between the cracks, that is my impression, in this particular area.

Senator **DURENBERGER**. So the cost wouldn't be as great as some people think.

Mr. **CZAJKOWSKI**. I don't think it would. The only thing that I would observe is that it might be a little unfair to those employers who are paying all of the health insurance, and who are going to work to provide coverage for the employees, and then those that don't do anything at all, they escape it. So you penalize the guy who is doing a good job. That is the one thing that I would say.

Mr. **TRIPPLER**. I just have one thing to add, Senator. In rural America the problem has been continuation, because of the economic crisis we are facing. We are having a tough time continuing our health care coverage.

Farming is recognized as the second most dangerous occupation in this country, right behind mining, according to the National Safety Council. Our concern is even finding coverage. When you are self-employed, involved in agriculture, or a small agribusiness, your concern is to locate coverage.

Because of the dangerous occupation, because you are not eligible for one of those employer/employee groups where you can just automatically just sign up and they don't ask health questions—our concern has always been locating health care coverage. Of course, with the economic conditions facing us, today, we are hearing from many of our members stating they are losing their health care coverage because they just can't afford it any more. This is our No. 1 concern, that is why I believe something like this, where you are at least allowing them a break, is needed very much in rural America.

Senator DURENBERGER. In the previous panel with Gail Wilensky, we explored a couple of issues, one of which was, shouldn't it be more efficient for everybody to buy insurance rather than have people just walk into hospitals, and have those with insurance subsidize those without.

Is there any disagreement that assuring that everyone has some insurance coverage would be a better way to go than trying to keep hospitals all over for people who don't have insurance?

Is there any disagreement on that issue?

Mr. TROY. I agree with that.

Mr. CZAJKOWSKI. These pool policies carry a whole range of benefits beyond merely the hospital care.

Senator DURENBERGER. Then the issue is the inequities between the third party contributors. Without getting into the inequities that might exist between a prepaid plan and another kind of plan, or between a nonprofit plan and a for-profit plan. Looking at it from the other side where the money really comes from, that is, in many cases, the third party financing coming from an employer, or some kind of an arrangement, it seems that the big inequity that I keep pointing to, of course, is large corporate exec versus small business people.

Even at the small business level, you have inequities because some employers have to fight for certain kinds of employees at the fringe benefit level. They have to get close to first dollar coverage because people want first dollar coverage. So if you want to have a skilled tool and die maker, or something like that, and even though you are small, you are competing with Honeywell, or some big company.

You are there as an employer, and there is almost a requirement that you pay a large part of those cuts, where some other employers have the luxury or maybe only paying $50 to $75 against $175 plan, and there is a lot of cost sharing. The subsidy for that is kind of inequitable.

In some cases, you don't have any income to write this stuff off against.

Do any of you have any observations about how we might make the Federal subsidy more equitable as between large employers, small employers, and employers differently situated?

Gail and I were talking earlier about a proposal of mine in which we would try to make available to everybody in this country a premium deduction, or some other form of subsidy. You would get a deduction whether you are a big employer, a small employer, or if you are self-employed. Whatever it costs to buy your health insurance, that ought to be a deduction against your income tax liability.

Mr. CZAJKOWSKI. I think that it is a good idea, Senator, because clearly the people who have to carry their nongroup coverage carry a big burden. They don't get any break at all, whereas the employed person, like the big corporate exec, is getting a big advantage. I think that there would be merit in those people who have to pay their individual coverage on their own to get some sort of tax break for that, just like an employer. We would certainly support that.

Senator DURENBERGER. John.

Mr. TROY. Our attitude, obviously, Senator, is well known to you. In connection with the employee benefit plan area, this is a wheel that works, and we didn't feel that that wheel should be tampered with unless we were pretty sure we knew where we were going.

In the past, in connection with the small employers, and those covered by small group plans, we have talked about things like special tax credits, or some way to generate the movement of the uninsured group of small employers into the insured category, by helping them through using the tax mechanism. I think that those kinds of thoughts were a better approach than the approach of getting rid of the deduction. Of course, we ran into all sorts of problems about adverse selection, and so forth, in connection with getting rid of the deduction. We gave that, I think, a pretty good shot in analysis.

Senator DURENBERGER. Aaron, how do you feel about the premium deduction?

Mr. TRIPPLER. This is one of CIA's strongest resolutions. All we are asking for is a fair share. We have not stated we want 100 percent. What we have said is, put a cap on the large ones, if you are thinking of that, and give us an equal share. We are not concerned with any specific wording.

Senator DURENBERGER. We wouldn't even have to do the cap on the large ones, that just happens to be my preference as the way to go to get the money because there is only so much around in this country. We wouldn't even have to do that, we would still have just everybody have the right to a deduction for the premium.

Mr. TRIPPLER. We have long supported that issue.

Mr. CZAJKOWSKI. I think it would encourage people to take out health insurance who otherwise are not taking it out, those who wait until they are stick, often then come under the Medicaid Program.

Senator DURENBERGER. One last question on the pooling arrangements. One of the questions I think I asked Gail was: Should we leave to the States the discretion of how they are going to finance these pools, so that they can decide whether they want a broad-based tax under it, or if they want premium taxes, or if they want to go after just certain kinds of plans.

Should we leave it to the States to decide from State to State how they want to manage these pools?

Mr. TRIPPLER. Senator, having testified in 25 to 30 States in the last 2 years on this issue, and hearing the different ideas and proposals, I definitely think you should leave it to the States. Each State looks, upon the need and their responsibility to health care a little differently than other States.

A good example, in Utah, they considered putting on a 1-percent hospital fee tax to support the pool should they pass it, or an increase in what we call the sin taxes. It might have worked in Utah, but the pool is not yet in effect.

Another example, Tennessee passed the pool this year, but put a $2 million cap on what the State will kick into the pool.

Alaska considered this year legislation to allow people who can't buy insurance the right to buy on the group State plan. It did not pass.

There are many efforts floating around out there, and many options. I believe States should be allowed this opportunity.

Senator DURENBERGER. Any other comments?

Mr. CZAJKOWSKI. I would support giving the States the flexibility also, Senator. In Minnesota, we have a little different arrangement there, and I think that we would like to maintain that arrangement. I think each State sees its responsibility maybe slightly differently, and why not give them the flexibility.

Mr. TROY. We like the way your pool is set up in the bill, Senator, and it gives the States the flexibility that they need, I think, to run effective pools.

Mr. DORSCH. I was just going to add one comment, Senator. With regard to the burden on small businesses, to the extent that you have pools set up as you do in Connecticut and Minnesota under present law, all of the pool losses now economically fall on small businesses and people who buy individual health insurance, because the large employers are self-insured and are excluded because of ERISA.

This means that if it is the insurers that pick pool losses under present law up, they don't have a money machine in the basement, they pass it all on to the small businesses that are too small to self-insure.

Senator DURENBERGER. Aaron said earlier, Wisconsin takes it a step farther, and apparently adds a direct subsidy to some of the smaller businesses.

Mr. TRIPPLER. About 30 percent of the people in Wisconsin are using the subsidy.

Senator DURENBERGER. This is another way to alleviate the burden on low-income people, or small businesses.

Mr. CZAJKOWSKI. There is nothing in your bill that prevents any State, if they want to subsidize low-income people to help buy into the pool. It is just a problem of the high cost of health care, which is another whole subject. To the extent that a State wants to subsidize low-income people, or people who don't have money to pay the high premium, there is no requirement that says that they can't do that.

Senator DURENBERGER. So we do have mechanisms so that we can make sure the burden doesn't fall in equitably on small employers in this pooling arrangement. It is available. We have the framework authority in this bill, but it would be up to the States to set it up so that the burden didn't fall on small employers.

Mr. TROY. Right.

Senator DURENBERGER. Gentlemen, thank you very much for your testimony. I appreciate it a lot.

We will now have to take a 5-minute recess, and I will be right back.

[Recess.]

Senator DURENBERGER. The hearing will come to order.

Our next panel includes Rick Curtis, director of health policy studies for the National Governors Association; Delegate Marilyn Goldwater of the Maryland General Assembly on behalf of the National Conference of State Legislatures, and Hon. Jim Rout, who is the chairman of the board of commissioners for Shelby County, TN, on behalf of the National Association of Counties.

Ladies and gentlemen, your statements will be made part of the record, and you may proceed in the order of introduction.

TESTIMONY OF RICK CURTIS,[1] DIRECTOR OF HEALTH POLICY STUDIES, NATIONAL GOVERNORS ASSOCIATION

Mr. CURTIS. Thank you, Mr. Chairman.

As you well know, over the last couple of years, large numbers of States, as a matter of fact, the majority of the States have been very active in trying to develop policies and programs to help meet the needs of the growing number of individuals who do not have adequate financial access to health care.

There are, of course, substantial constraints on States ability to address these problems. A fundamental economic constraint is that uninsured poor people tend to be concentrated in those areas of the country that have the fewest resources to meet their needs.

That, combined with the fact that there are constraints in Federal law that restrict States latitude to extend private insurance plan coverage to other uninsured populations, make congressional review of this issue and Federal action to help address this issue appropriate.

Although the intent of the bill that is being discussed today is commendable, you will not be surprised to hear that several of the specific mechanisms it contains would be problematic for States.

While the Governors do not have specific policy positions on these provisions, they do have a clear perspective regarding the broader issues of appropriate Federal and State roles raised by the bill. We are, therefore, greatly appreciative of your decision to solicit input on the bill in your role as chairman of this particular subcommittee.

As you have emphasized for years, Mr. Chairman, Federal policies to develop a price sensitive and cost accountable health care system drive out the many implicit cross-subsidies that have heretofore existed. That is no longer a theory. It is now fact. I think the point to emphasize here is that the access problems we are seeing are not due to some sort of irresponsible or arbitrary action by everyone but the Federal Government, and it would seem logical that, therefore, the fiscal responsibility for solving the problem should not be mandated to fall on everyone but the Federal Government. I was glad to hear you mention your opposition to unfunded mandates earlier today.

The demographic factors and the economic constraints that often limit the ability of individual States to meet the growing needs for health care financing are indeed significant. States with disproportionately large indigent populations like Mississippi tend to have very limited revenue bases to meet the needs of the poor.

Further, individual State economic conditions are increasingly limiting the capacity for expenditure increases even when the national economy is prospering. The economic bases that States rely on are increasingly vulnerable to factors completely beyond not only their control, but national policy control as well.

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[1] See p. 154 for Mr. Curtis' prepared statement.

For example, right now, States with energy- and agricultural-based economies have experienced sharp revenue declines due to vagaries in international markets. In fact, 17 States, had to impose significant budget cuts during the fiscal year that is just now closing.

These economic realities make a substantial Federal role in financing health care for the poor essential. As you know, Governors have, therefore, held that the Federal Government should be principally responsible for health care financing and other programs to meet the needs of our poorer citizens.

The Governors also, of course, always strongly oppose Federal mandates for State taxes and State spending, especially where no Federal taxes or spending are committed. That general position, of course, would indicate a strong opposition to section 3 of the access to health care initiative bill which mandates States to either establish a subsidy for charity care, or provide health insurance for all residents.

That provision is particularly troublesome because there is not even a proportional Federal contribution to the subsidy, and because Federal Medicaid funding, the only significant Federal role in financing care for the poor, would be terminated if the State did not comply.

I would also just quickly mention that the States in weak economic condition would probably have the same problems as other employers with a requirement that they continue coverage for 4 months for laid-off employees.

Although economic factors limit the ability of States to address the problems of the poor, they are, of course, not as relevant to determining which level of government should improve coverage for populations not in need of public subsidies. The differences in the economic infrastructure and demographic characteristics of States suggest that they may be in a better position than the Federal Government to target solutions.

I would point to everybody's favorite State today, Wisconsin, as an example of that. It is really a small component of their very comprehensive planning effort to address the needs of the uninsured. They are surveying small employers, and small employers' employees to determine why, in the case of employers, they are not offering insurance and how they might be induced to do so. Other information they are collecting relates to the family incomes of employees and what they could afford to spend on health insurance. That kind of information is going to vary from State to State and will be very useful to targeting solutions that will work in the given States.

The ERISA preemption has been mentioned a number of times; I won't belabor it. It, obviously, is a constraint on States' ability to design such programs. We do have some problems because it is a rather prescriptive approach, and we would instead suggest that, because of limited experience with these models, and substantially different socioeconomic and health care delivery contexts in each State, uniform mandates of that nature should be avoided if at all possible.

I would also like to very quickly mention that there is another very important Federal role that you have been dwelling on for some years now. Very clearly, either redistribution of Federal tax expenditures or an extension of those tax expenditures for people who in most need would greatly assist efforts of States and the private sector to solve this problem.

The other thing that I would like to quickly mention, of course, is Medicaid's role as the principal health insurance program for the poor. You have cosponsored bills to enact the proposal the Governors have made to extend coverage to poor pregnant women and infants. Those proposals will not only provide cost effective care to that population, but would also help to reduce this uncompensated hospital care problem because those costs disproportionately arise from neonatal intensive care services, and, of course, those costs should be reduced if we have adequate prenatal care for our Nation's poor.

The Governors look forward to working with you and your staff to refine workable and affordable strategies toward meeting the needs of our uninsured population.

Thank you, sir.

Senator DURENBERGER. Thank you very much.

Marilyn.

TESTIMONY OF MARILYN GOLDWATER, MARYLAND GENERAL ASSEMBLY, ON BEHALF OF THE NATIONAL CONFERENCE OF STATE LEGISLATURES

Ms. GOLDWATER. Thank you very much, Mr. Chairman.

I am testifying on behalf of the National Conference of State Legislatures. You have our detailed statement,[1] and I would just like to share some thoughts with you on Access to Health Care Act of 1986.

I know that you are well aware that States are grappling with the problem of providing health care services to the medically indigent, the uninsured, the unemployed, and their dependents, and to economically and efficiently assist hospitals with the problem of uncompensated health care. It is a very complex and difficult dilemma that States and counties are faced with daily.

It is particularly noteworthy and troublesome, I think, that many people lack access to health insurance under our current system because most insurance is, indeed, employment-based. As new employment trends emerge and more people work part-time in a variety of settings and temporary positions in small business or are self-employed, increasing numbers of individuals and families will be unable to obtain health insurance.

Many of these individuals and families could afford health insurance at a group rate, but cannot afford coverage on an individual basis. This has been an area of personal interest to me, and as a result I introduced legislation recently signed into law that authorizes the Maryland Insurance Commissioner to develop a health insurance program for those working people and their dependents that do not have access to insurance at a group rate.

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[1] See p. 160 for Ms. Goldwater's prepared statement.

The commissioner plans to put the program out for competitive bid to both for-profit and nonprofit health insurance companies, and award the contract on the basis of bid. After the contract is awarded, there will be extensive marketing of the program. The program will be self-supporting through the premiums.

We are the first State to initiate such legislation, and we hope that we will have a positive experience that other States can use as a model. We worked with both the Maryland chamber and the insurance industry to develop this bill.

In addition, we enacted three continuation bills to cover for 18 months the surviving spouse or the divorcee in the involuntarily terminated workup. Individuals who lack health insurance were unable to pay the individual coverage or health care services, and cannot seek coverage through existing channels due to the health status, income or employment status, or people who fall through the cracks of our health care system, should be the focus of our concerns today.

Nationally, there is no system in place to take care of these people. States, however, have sought the assistance of the local governments and the private sector to fulfill their social obligations to provide access to health care. Our attempts may be incomplete and new, but we have recognized the need and made efforts to fill it.

Our major concern with the access initiatives presently before you is that it sets the responsibility for financing health care for the indigents squarely on the shoulders of the States, without a Federal commitment to address the problem of extending access to health care to all of our Nation's citizens.

Federal mandates without Federal financing does not do very much to foster and advance the State/Federal partnership which is necessary to ultimately resolve this national problems. NCSL believes that a Federal commitment to action should include at least some Federal funds to implement the identified remedies.

In addition, two major elements, not addressed by this legislation, are catastrophic illness and long-term care. Both States and counties are seeking solutions in these two areas. Federal mandates of the magnitude of those contained in this legislative package are usually reserved to areas where States are perceived to be inactive or remiss in their responsibilities. I do not believe that States are remiss or inactive in trying to deal with this problem.

This package would intrude in an area where States have taken the lead, and have provided some solutions.

I would like to just sum up by going to the last page of the testimony, which is just a short list of observations.

This legislative package inappropriately places primary responsibility for indigent care on the shoulders of the States.

The legislative package, if enacted, would be costly to the States, and no additional Federal financing assistance is provided for.

The risk pool initiative makes no provision for grandfathering in existing State programs and could result in substantial costs to States through direct or indirect subsidization.

The uncompensated care initiative may encourage use of hospitals for primary and preventive care, discourage competition, and frustrate State and private sector initiated cost containment efforts by providing preferential treatment to hospitals over alternative delivery systems.

The development of alternative insurance instruments for the unemployed, part-time workers, seasonal, and temporary workers, and others who cannot afford to buy individual health insurance should be pursued by the Federal Government and given a high priority.

Ways to make health insurance more affordable for small businessowners should be investigated.

We look forward to working with you on this legislation, and thank you for the opportunity to share our thoughts.

Senator DURENBERGER. Thank you very much.

Mr. Rout.

TESTIMONY OF JAMES L. ROUT, CHAIRMAN, BOARD OF COMMISSIONERS, SHELBY COUNTY (MEMPHIS), TN, ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES

Mr. ROUT. Thank you very much, Mr. Chairman, for this opportunity. We will condense our comments. We do have a statement[1] submitted for the record, but we have some very brief comments that we will make for the sake of time here.

As the steering committee vice chairman for the National Association of Counties, I appear today also as the chairman of the Board of Commissioners of Memphis, Shelby County, TN, where Chancellor Jim Hunt said to tell you and Chip Kahn, "hello"; Chancellor Hunt formerly with the Mayo Clinic, I believe.

NACo has long been interested in the problem of access to health care in the United States. Historically, as you know, and most of us have observed over the years, counties have been the providers of last resort for the health care of the poor and indigent. As some will refer to it, counties are where the rubber hits the road.

In our county, Shelby County, Memphis, TN, we put almost $60 million annually into our two nursing homes that we provide as a county entity, and also our public hospital, our regional medical center at Memphis, and into our neighborhood clinics. That is to make up the financial shortfall on an annual basis that results due to those patients who cannot pay, or can only pay a very small portion of their bill.

Despite some popular misconceptions, county treasuries are hard pressed, as you probably know, to pay the bills of indigent and poor patients. We cannot replenish our resources because our taxing power too often is constitutionally limited, or we are stretched to the breaking point in many counties in the United States.

Our taxpayers, through the local ballot, have sent us a clear message that their willingness to pay has practical limits attached to it. NACo believes that the problem is national in scope as has been pointed out by the two previous speakers on the panel, despite reasonable variations in severity.

As a national problem, access to care demands a national solution, that is why our association's fundamental policy document, the American County Platform, argues for a Federal system of financing health care. We recognize that national financing of health care is not in the foreseeable future, and the problem of access to health care is an immediate concern for some 37.1 million Americans. Thus, the initiative proposed in S. 2403 is welcome as a partial solution to a pressing issue. We commend you for that, despite some reservations that we have with it.

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[1] See p. 172 for Mr. Rout's prepared statement.

As you review the legislation, we ask that you consider the following:

One, some of our counties are self-insured, as you know. They have expressed a desire for greater clarification of their status under the provisions of this bill.

Two, we believe the subcommittee should carefully review the experience with risk pooling in those States which have enacted such legislation. It may be that such pools do not provide the anticipated results because of prohibitive participation costs as was pointed out by an earlier speaker.

The National Association of Counties, Mr. Chairman, is concerned that risk pooling may create an inducement for additional insurers to dump high risk persons into the pool, instead of offering mainstream coverage options. We are somewhat apprehensive also about the mandate that States develop indigent care plans without knowing how States would finance such plans or the details of how those plans could work, and we cannot predict their impact on county operations or financing.

Let me deviate for a moment and say that Mississippi, our bordering State within 25 minutes of our medical center and public hospital in Memphis, last month abolished their hospital commission, and we are sitting with a $2.5 million shortfall for indigent care for Mississippi where the payment was only $65 per day to start with, and an average cost in our hosipital of over $500 per day.

These are concerns that we have relative to State-by-State situations.

The Medicaid penalty for noncompliance to access is somewhat ill-advised, perhaps. Even though the penalty might be restricted to the administrative payments to States, it will still have a negative impact on beneficiaries through delays and disruptions, and inability determinations in claims processing, and service delivery.

We sympathize with the motive which gave rise to the bill's provision mandating an extension of coverage for unemployed workers under the same terms and conditions as if they were still employed. However, we are concerned with the fiscal impact of this approach.

Financially strapped counties, and there are many of them today throughout America, are the very ones most likely to be seriously hurt by extended coverage. Forced to RIF because they cannot afford to maintain existing service levels, are they then to be financially squeezed even more by a mandate of this type?

In short, Mr. Chairman, NACo believes that S. 2403, is a positive and a creative contribution to the dialog over the issue of providing access to health care for the uninsured and the underinsured. We prefer national financing of our health care system, but in its absence we view this measure as worthy of serious consideration, and commend you for your leadership.

NACo looks forward to working with you in refining the bill and addressing the issues that we hopefully have helped to raise here today.

Thank you.

Senator Durenberger. Thank you, Jim.

Your statements will all be made part of the record, and I am going to ask each of you to be responsive to some questions that particularly relate to State pooling tax bases in various States and to respond to variations of these mechanisms that have been proposed.

Somebody mentioned Wisconsin, and because we are neighbors, I am particularly proud of the fact that at the time that the country went to Social Security, or passed the Social Security Act in 1935, there was only one State in this country that had the guts to have an unemployment compensation system, and some form of social insurance system in effect, and that was our neighbor Wisconsin.

I always make the argument that the other 49 wouldn't do it, and Wisconsin would not have lasted very long if we hadn't gone to some kind of national system, because eventually by taxing employers in Wisconsin for an unemployment compensation system, it would have driven all employers into other States.

We still have some semblance of that problem, and we are going to have a person here from Minnesota a little later on, and if we give him a little time, he is going to talk a little bit about how the combination of social insurance taxes on employers in this country is contributing or can contribute in some way to the change in location of employment. We certainly are seeing a lot of that.

Obviously, starting with the Social Security Act of 1935, and then following that up over the last 40 years, we have sort of built in a sense, as Marilyn said, of national responsibility. We didn't think that in 1935, and I don't know whether we think that today. Maybe this is the time that we sort of retest it.

Part of the test here is, is there a national responsibility to provide access to health care for every American, and I think that we all feel that. How we do it gets to be tough.

Jim says that we, down there in Shelby County, Memphis, are having to put a lot of money into nursing homes and hospitals. My philosophic approach is that we don't put money into nursing homes and hospitals, but we put people into them, and the people ought to come with the money. They ought to be able to choose whether they go into a nursing home, or if they want to stay home, or whatever. We would have a lot more efficient system in this country if out there the people were able to make choices, and they were not being forced into nursing homes, or if they were not being forced to go into that hospital, and things like that.

To say that the Federal Government ought to do more of the financing would be to ignore the fact that we sort of set out in this country to do a lot of indirect financing. Certainly, you benefit from the 501(c)(3) status in a lot of hospitals and nursing homes out there at the local and State level. You benefit from tax-exempt bond financing, and that is why you are so helpful to me in maintaining tax exempt bond financing. You benefit from the deductibility of State and local taxes, if we can maintain that one. You benefit from the health premium deduction that the employers in our State have, they can write off their contribution to health premiums, and employees are not taxed. In that one, it is a little bit of an uneven subsidy.

In my State, General Mills tells me that they are in the 42-percent tax bracket, so their premium deduction is worth a lot more than somebody who is not paying taxes this year because they are in hard times, and they are putting all of their money into their employees and trying to get out a product. They are in a loss situation taxwise, but they still have to pay those insurance premiums, so they are not getting the benefit. They are not getting a 42-percent benefit for the deductions.

We have some inequities in the way we contribute, I think, at the national level. That is just my way of making a speech, maybe, but I think that we have all been together here enough to understand that it is not like the Federal Government is giving you more mandates without being there to try to be helpful.

When we talk about the pooling arrangements, and bringing in the private sector, and private health plans, and so forth, we are there with the indirect tax subsidy. Our problem here today, I think, is trying to figure out whether or not this bill of ours is falling unevenly between States or between large employers and small employers, or whatever the case may be. I don't want to drive any more Minnesota business into Tennessee——

Mr. ROUT. We will accept them, sir.

Senator DURENBERGER. I know, you have been accepting them for a long time.

Mr. ROUT. We are even recruiting them.

Senator DURENBERGER. I know, and you have been recruiting them for a long time, and that is part of the problem.

Let me ask one specific question, since you are all three here in an association capacity. In the State of the Union Message, the President said that we are going to welfare reform. I can't hear it being done. I could hear tax reform being done in 1984, but I am on the Finance Committee, and we have at least some part of welfare reform, but I can't hear welfare reform being done.

I am just curious to know from the Governors and the Conference of State Legislatures, and from NACo, are you deeply involved in this process of welfare reform?

Obviously, what we are talking about here, accessing the indigent to some kind of health care system, I would guess that by this time next year we ought to be in hearings in this subcommittee on welfare reform, and the impact that is having on what should the role of the States be in the reform of welfare, and articulating a national approach to this, with a State-based decisionmaking system.

The 37 million people that we are talking about, not all of them, but most of them are going to fall somewhere between the private insurance system, the social insurance system, and the welfare system. If we are reforming the welfare system, I guess you all are involved in some way or another in the process; is that true?

Mr. CURTIS. I personally am not as a health staffer, but the Governors Association does indeed have a task force that is developing a strategic plan for the Governors to both assist the States in redesign of programs under existing authorities, as well as look at substantial changes in Federal law.

It is our impression, given the statements that White House staff, in fact, made to the task force of the Governors just the other day, that at this point the administration is looking at demonstration models at the State and local level, rather than major Federal legislation in the coming year. Legislation would be more on the order of some sweeping authority across programs to give, I assume, the demonstration authority to the administration to allow States and local governments to consolidate financing across not just programs in a given category, but across programs that address the needs of given populations across committee jurisdiction in the Congress and the departments within the executive branch. I assume that this is why you are not hearing much about it.

You brought up Wisconsin. There was a more focused point there. Obviously, the change in law that would bring self-insured entities into pools for uninsurable individuals will help substantially. The way the bill is now constructed, those pools would also have to be opened to nonuninsurable individuals. Wisconsin happens to now, as most of the other States with these pools, constrain it to uninsurable individuals. Connecticut opens it to everyone.

In Wisconsin, they are looking at potentially opening up that pool to other populations and/or developing other pools. They are not sure what they would do. But this legislation would require them to take a given course.

Senator DURENBERGER. You don't think that that is too good an idea.

Mr. CURTIS. No; States should have more latitude than that.

The other point I would make, and I think it is a point of clarification, a number of people mentioned that Wisconsin has general fund revenue subsidized supplements to lower income people, to make those premium payments more affordable. It does not make it affordable for the really poor. What it does is reduce the premium from 150 percent for most people down to as low as 105 percent. So it is still much more expensive than truly low-income people can afford, and Wisconsin is looking at those populations as well.

Senator DURENBERGER. Marilyn.

Ms. GOLDWATER. I would add that NCSL is certainly interested in welfare reform, and it is looking at it. It is particularly concerned with the health benefits that accure to those individuals. In our State, we are also looking at, and other States are beginning to look at it, too. We have several demonstration projects in our State in various counties.

We have one where we have 100 AFDC parents in Montgomery County who are in a job program, and we work with the Center for Prepaid Health Insurance and with our Medicaid people to assure that the AFDC parents, even though they have a job, would continue to get their Medicaid coverage. We will evaluate that after about 1 year.

I think that there are a lot of things going on. In addition, our county, as you probably have read in the Post, has passed legislation on catastrophic insurance, which is another interesting aspect that needs to be looked at.

Mr. Rout. Mr. Chairman, I will agree, and keep it brief, with the other speakers.

We also have, from the National Association of Counties, Tom Joseph who is involved in the task force. I think where we are today is that it hasn't trickled down to where there is anything that has come out of these task forces at this point in time of great substance. Fortunately, we are moving in that direction.

Let me shift gears for just a moment and pick up on some comments you made, if I might, sir. One was relative to the issue of financing people, or financing institutions. I agree with you, we would much rather have the issue, and we like to think, in Memphis, that even though we say that we put that money in the institutions, we are truly financing the people.

The reality on the street today in Memphis, TN, at this hour is that there are people who will be turned away from some of the private hospitals, who share, in fact, some of the very same benefits that you pointed out, tax-free bond, they are 501(c)(3) corporations. They have tax-exempt status as far as their surplus or margin, and yet one of those, the largest in the Nation, had a $48 million surplus last year.

We are concerned, and we would rather be seeing things happen that would have them involved more adequately instead of having to see people come into our emergency rooms, even in some cases with an IV still in their arm, from across the street.

These are the kind of things that are realistically happening. We are trying to point out, to make certain that, as you move forward in these hearings, those kinds of problems are not in there, and that those people do not get additional funding, without carrying out a responsibility they already have based on some Federal issues that are at hand with them, and that they get to enjoy.

Senator Durenberger. Thank you all very much for your testimony. I wish we had more time to spend at it.

Our next panel consists of Mr. Jack Owen, executive vice president of the American Hospital Association; Mr. Howard Newman, senior partner of Powell, Goldstein, Frazer, & Murphy, on behalf of the National Association of Public Hospitals; Sister Dolores Super, chairperson of the board of trustees of the St. Cloud Hospital, and academic dean of the College of St. Benedict, on behalf of the Catholic Health Association; Gail Litfin, a volunteer, who is here on behalf of the American Diabetes Association; and Ms. Lou Glasse, who is president of the Older Women's League in Washington, DC.

Jack Owen, you are first up. I will remind everyone that their statement will be made part of the record. If they would limit their statement to 5 minutes, those who want to go to lunch will surely appreciate it.

TESTIMONY OF JACK OWEN,[1] EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. Owen. Thank you, Mr. Chairman.

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[1] See p. 182 for Mr. Owen's prepared statement.

I am Jack Owen, executive vice president of the American Hospital Association, and I am delighted to be here today in support of a bill that you are responsible for, which is a good bill, and we are on our way.

The highest priority for our association is finding a solution for the growing crisis of medical indigence. In February 1986, the AHA board's special committee on care for the indigent completed a report called, "Cost and Compassion: Recommendations for Avoiding a Crisis in Care for the Medically Indigent," which outlines a series of long- and short-term public and private initiatives which could be adopted to avert a crisis.

The report shows the problem's startling and growing dimensions, and your charts up there have also pointed this out. Medicaid now covers less than 40 percent of the poor. Medical indigence is again becoming a problem for a large and increasing number of Americans and, therefore, a major policy issue for Federal, State, and local governments. I am delighted to see the hearing over here in this subcommittee.

A sizable percentage of the population is unable to obtain private insurance and does not qualify for public insurance programs. Persistence of a large population without adequate health insurance imposes large costs on all members of society, and you have heard that today.

Currently, the major financing mechanism for the medically indigent is unsponsored care or so-called free care. As you and I both know, there is no such thing as free care in a hospital. We have to pay salaries, supplies, and everything else. So this free care is provided by hospitals, and it is largely subsidized by private-pay patients.

Unsponsored care has more than doubled between 1980 and 1984. Competitive pressures on private insurers and providers increasingly are limiting availability to cross-shift subsidy. These trends threaten to limit access to care by the poor and, therefore, jeopardizes the viability of a competitive approach to health care.

If a method of financing care for the medically indigent within a competitive system cannot be found, pressure to return to more regulatory methods may indeed become necessary. An enduring, long-term solution to the problem of medically indigence will require initiatives by both the private and public sectors to reduce the size of the medically indigent population through adequate private insurance and to restructure and extend Medicaid so that it does a better job of covering those who cannot obtain private insurance.

In keeping with the time factor, I will not repeat what we approve in the bill, but only cover those points in which we feel some amendments might be necessary.

In particular, the association has several objections to section 3, the section on uncompensated care pools, or State-financed health care plans. In general, the mandate approach in this section is acceptable as a short-term stopgap solution, but only if it is structured carefully so that the costs are broadly spread, and only if it is accompanied by some evidence of good faith at the Federal level.

Of the two alternative solutions contemplated in this section, State-financed care for the medically indigent and the creation of uncompensated care pools, the first is clearly superior because it would make possible a broader and more equitable financing base, and a more cost-effective delivery system. We are concerned that we would have a hospital tax, in other words.

Section 3 of the bill should be amended to permit States to build on the existing Medicaid Program with Federal financial participation to fulfill the requirements under the first alternative.

The association does not support the House version enforcement provision barring hospitals from participating in Medicare if the State does not participate.

The method of financing the uncompensated health care plan should be more fully delineated to assure that responsibility does not lie solely with the hospital, but is shared by all sectors of our society.

Hospitals have a role to play and should play a role, but all members should also have a role.

On the business side of it, I am sure that the business people will speak to their points, but I would just mention four very briefly that we think would raise some concerns, and we want to see this bill pass.

First, it places a burden on already insured firms, and we think that it should be looked at carefully.

Second, it exempts, Federal, State, and local governments from the pool, which makes pooling that much more difficult for the industry. Tax money is not designated. What happens to the tax money if a State sets up a plan and decides to use the tax for something else.

Last, 10 percent maybe preferable to an assessment if you look at a large firm, and they say, we don't know what our assessment is going to be, we will take the 10 percent.

We are looking forward to working with you on this bill, and we are delighted that you are moving in that direction.

Senator DURENBURGER. Thank you very much.

Mr. Newman.

TESTIMONY OF HOWARD NEWMAN,[1] SENIOR PARTNER, POWELL, GOLDSTEIN, FRAZER & MURPHY, ON BEHALF OF NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Mr. NEWMAN. Mr. Chairman, I appear before you today as special counsel to the National Association of Public Hospitals, those are the providers of last resort, and sometimes euphemistically referred to as the safety net.

You heard earlier today from Shelby County, TN, Regional Medical Center of Memphis, a member of the association, and a typical example, I would say, of an institution which has maintained the principle of open access to all even in the face of the exigencies of a competitive health care system.

There has been some help provided to these institutions, most notably recently the disproportionate share Medicare amendments in COBRA, and your efforts in that regard are deeply appreciated by the association and its members.

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[1] See p. 206 for Mr. Newman's prepared statement.

We endorse the thrust of the bill before you today. We applaud the effort which acknowledges that there are and will continue to be, in the foreseeable future, vulnerable individuals who will require public assistance from all levels of government in order to cope with the threat and often the reality of medical indigence.

I would like to offer just three brief comments this morning in light of the time constraints.

First, because of the complexity of the issues identified in this bill, and the recent history of reluctance on the part of some Federal regulatory agencies to carry out the clear congressional intent, we would urge that the references to such terms as "adequate payment levels," and "unreimbursed costs" in section 3 of the bill be given greater detail in statutory language.

The second point I would make is based on the fact that earlier in my life, I spent 5 years trying to run the Medicaid Program in what was then the Department of Health, Education, and Welfare, and I think there are some lessons that we need to learn or acknowledge from the Medicaid experience. One referred to earlier by several of the previous speakers is the reality that with Federal financial participation, the States have clearly been able to do in Medicaid what they would not have been able to do on their own.

However, the financial and administrative capacity of States vary, and while it is admirable to encourage innovation and a variety of approaches, there is in what you have correctly identified, in my view, as a national problem, a need to adhere, at least to some degree, to a set of national standards. I consider, for example, the need for some definition of "minimal benefits" as a lesson that we should have learned from Medicaid.

Third, and also with regard to the lessons of Medicaid utilization control penalties, sanctions must be proportionate the harm caused by the action, or we will find that the sanctions are, in fact, unenforceable.

Finally, I would just like to make one additional point, which is peripheral to the bill that is being considered today, but which we would like nevertheless to note. Senate bill 2403, from the institutional perspective, addresses the financing or operating costs of servicing uninsured patients. The capital needs of public hospitals will be the subject of discussion for another day. I would like you to be aware of the fact that the National Association of Public Hospitals is currently studying the potential impact of various federally sponsored insurance or credit enhancement vehicles for institutions as well as for individuals and we would welcome an opportunity, at the appropriate occasion, to discuss those thoughts and ideas with you and members of your staff.

Thank you very much.

Senator **Durenberger**. Thank you very much.

Sister Dolores.

TESTIMONY OF SISTER DOLORES SUPER, CHAIRPERSON, BOARD OF TRUSTEES, ST. CLOUD HOSPITAL, AND ACADEMIC DEAN, COLLEGE OF ST. BENEDICT, ON BEHALF OF CATHOLIC HEALTH ASSOCIATION

Sister DOLORES. Thank you, Mr. Chairman.[1]

On behalf of the Catholic Health Association, whose membership includes over 900 hospitals and long-term care facilities nationwide, including the hospital whose board I chair in St. Cloud, MN, I am grateful to have this opportunity to appear before you this morning in support of your bill, the Access to Health Care of 1986, S. 2403.

It greatly encourages me and is a source of hometown pride to have you take a leadership role in addressing the alarming and growing incidence of medical indigence in the United States. Our country correctly believes that it has the premier health care delivery system in the world. Nevertheless, the fact that millions of Americans still do not have access to adequate or necessary health care raises fundamental questions about the system's integrity from the point of view of justice.

As you know, Mr. Chairman, several factors explain why insuring the availability of health care services for the poor has become such an urgent concern. A marketplace environment, driven by competition among health care providers, requires that persons pay for the services they need.

In such an environment there are few, if any, economic incentives to provide care for those unable to pay. Because many poor persons lack either public or private health insurance, and many more are under-insured, their access to health care services is seriously diminished. That is one reason, and we have heard others mentioned this morning.

In April, the Board of Trustees of the Catholic Health Association adopted a report of a task force on health care for the poor entitled, "No Room in the Marketplace: The Health Care of the Poor." Over a year in the making, this report contains a series of recommendations aimed at challenging Catholic health care facilities, the Catholic Church in the United States, and Federal and State governments to better ensure health care services for the poor and those without health insurance or sufficient health insurance.

We have provided you with a copy of this report, and we have submitted a copy for inclusion in the record of these proceedings.

Mr. Chairman, CHA continues to believe that universal health insurance remains the superior method of ensuring access to health care for all. However, until that ideal becomes politically achievable, we strongly support interim legislative initiatives such as your bill, S. 2403, and its companion bill S. 2402, sponsored by Senator Kennedy.

In particular, four of the five key elements of your bill are similar to recommendations proposed in the CHA task force on health care of the poor.

Both seek an extension of employment-based health insurance coverage for laid-off workers and their dependents.

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[1] See p. 232 for Sister Super's prepared statement.

Both seek the establishment of subsidized State health insurance pools to allow persons without access to employment-based coverage to buy individual health insurance regardless of their health status.

Both would require States to establish a mechanism to fund hospital charity and unreimbursed care.

Both would change the tax laws to encourage more employers to provide health insurance to their employees and employees' dependents.

Encouraged by your initiative and challenged by the recommendations of the CHA report to our own institutions, the Catholic Health Association is desirous of working with you and other like-minded groups and associations to ameliorate the problems facing our Nation's health care poor. S. 2403 is an important and necessary step in that direction.

CHA also applauds the chairman's sponsorship of S. 1620 which would create a National Council on Access to Health Care. The council would further examine problems relating to the quality and acessibility of health care services in the United States.

On behalf of CHA, Mr. Chairman, I thank you for your leadership on both of these initiatives. I would be happy to answer your questions.

Thank you.

Senator DURENBERGER. Thank you.

Gail.

TESTIMONY OF GAIL LITFIN,[1] VOLUNTEER, ON BEHALF OF AMERICAN DIABETES ASSOCIATION

Ms. LITFIN. Mr. Chairman, my name is Gail Litfin. I am 28 years old, and I have had diabetes since I was 9. I am here today because I am unable to obtain health insurance. I am representing the American Diabetes Association, and the Coalition for Health Insurance Availability, a coalition comprised of 44 national organizations seeking legislation to help people who currently are unable to obtain health insurance. The coalition's statement is attached to my own.

We all wish to express our strong support for the provision on pooled risk health insurance contained in the Access to Health Care Act of 1986.

In addition to my diabetes, I suffer from numerous complications. I am blind in one eye and see very little with the other. I have no real night vision. I have had problems with tissue inflammation in my legs for which I have had to be hospitalized, and I will need a kidney transplant in the near future. Right now this is my major concern. It seems that I would have to have total kidney failure before I could get any help.

When I was growing up, my father worked for Social Security. His salary started at about $9,000 a year. My mother did not work because she had five children, and three of us were diabetic. We were all covered under my father's Blue Cross and Blue Shield insurance policy, which he had through his work. This policy was good for emergencies, but did not cover routine doctor visits, syringes, insulin, or the supplies needed for urinalysis.

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[1] See p. 239 for Ms. Litfin's prepared statement.

We could only afford to go to the doctor to have our blood sugar tested about once a year. Blue Cross and Blue Shield would have paid for part of these visits, but we could not afford the $100 deductible for each child.

My sister with diabetes is now married to a man in the Coast Guard and is covered under his insurance policy. My brother, Mark, is dead. He died 10 days before his 21st birthday from giving himself too much insulin. Before he died he was in a coma for 5 weeks. It was almost a relief when he died because on his 21st birthday, he would no longer have been eligible under my father's insurance plan, and we didn't know what we were going to do since he needed continued hospitalization or nursing home care.

In 1980, I completed my bachelor's degree in media/communications. Following graduation, I worked for 3 years at the Baltimore Community Relations Commission as an investigator for EEOC complaints. When I worked for the city, I had Blue Cross and Blue Shield health insurance, but, like before, it didn't cover routine care or office visits, or the supplies and insulin that I needed. I believe that many of the problems I have had and those of my brother and sister could have been avoided if we had had better insurance coverage.

In 1983, I joined an HMO which was supposed to cover a lot of my supplies and routine office visits, but it turned out that wasn't true. In addition, they refused to pay for my insulin pump.

When I was laid off in 1983, I was able to convert to an individual insurance policy, but I couldn't keep up the $120 monthly premium since I didn't have the income. Also, at this point, none of my diabetes-related health needs were covered.

Soon after, my eyes got worse, and I was declared legally blind. I applied for and got Social Security disability insurance, and I now receive $551 a month, but I am still waiting for the 2-year waiting period for Medicare to be over.

The $551 is not enough to cover my health care needs in addition to living expenses. My monthly budget should be a little bit over $260 a month. However, I cut corners. Instead of changing the plastic tubing in my pump every day, like I am supposed to. I make it last 6 or 7 days. I am really not supposed to do that. This mechanism is my pump and the syringe and the reservoir should be changed to insure sterility, so that the insulin flows properly.

Also I test my blood sugar twice a day, but I am supposed to do that three or four times a day. I feel safe to be able to do it twice a day, and get by.

It is not an easy life, and I continue to collect medical bills and be threatened by bill collectors. I try to carry on a normal life, but the health insurance thing is pretty overwhelming.

I found that to be eligible for the State medical assistance program, I have to incur over 1,300 dollars' worth of medical bills every 6 months. I have met the criteria but some of my bills were for eye surgery and were just too old to make me eligible for this program.

I realize that the pooled risk health insurance programs have premiums that would currently be rather high for me, but I am attending classes to complete my master's degree and be able to work eventually, and I believe that my right eye will improve.

I want to be able to go back to work and pay for my own health insurance. I would like to freelance, but I know that I couldn't go and do that and be covered through an HMO, or obtain other insurance with my preexisting conditions. They don't like that.

Senator DURENBERGER. Gail, are you getting near the end of your statement?

Ms. LITFIN. Yes, I am.

I think that it would be the answer for me, the pooled risk health insurance, and I would like to recommend a sliding scale for payment.

Thank you.

Senator DURENBERGER. Thank you very much.

Lou.

TESTIMONY OF LOU GLASSE,[1] PRESIDENT, OLDER WOMEN'S LEAGUE

Ms. GLASSE. Thank you, Mr. Chairman.

I am Lou Glasse, president of the Older Women's League. The Older Women's League is the first national membership organization to focus on the concerns of midlife and older women, and health access and health care—affordable health care—is one of our major concerns.

We appreciate this opportunity to discuss this bill and to appear before you to share concerns that older women have.

You know that estimates of the medically uninsured range from 20 million to 37 million. By any count, a majority of Americans under age 65 have some health insurance through private plans. About 85 percent of private coverage is group coverage, and most of that is through employment.

As long as individuals are covered in employment, or related to employed workers, they have health insurance. A change of work or family status, all too often, means a loss of health insurance.

While both men and women lose health coverage when unemployed or laid off, women also lose coverage when they are widowed, divorced, or their husbands retire. Thus health coverage for women is highly dependent upon marital and work status.

About 5 million women between the ages of 40 and 65 have no health coverage, no protection against the cost of catastrophic illness, and limited access to any health care. Women are more likely than men to be medically dependent because of lower labor force participation rates, and higher rates of employment in part-time or low-wage service jobs without health benefits.

Most married women, even if they are not in the labor force, have private health insurance. But only about half of widows and a third of divorced women not in the labor force have such insurance. Among women under age 65, 40 percent of divorced women, and 25 percent of widows not in the labor force depend on Medicaid.

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[1] See p. 244 for Ms. Glasse's prepared statement.

Midlife women are not only more likely to be without health coverage than men of the same age, but they are also at greater risk than younger persons, recognizing that the previous person was an exception to that. However, because older women are more likely to need greater hospital care, therefore, their need for health insurance is greater.

Since it was founded in 1980, the Older Women's League has advocated for access to health insurance—affordable health insurance. As you know, Senator, we were certainly involved in working to promote spousal health insurance continuation, and we very much appreciated your Health Equity and Fairness Act that was passed, S. 2111 and related bills.

With your leadership and support, the provisions from these bills were included in the 1985 budget reconciliation bill signed into law in April.

Let me say that when it is fully implemented, the law will protect many Americans against this sudden loss of coverage at a vulnerable time, when they are unemployed, divorced, widowed, or their spouses retire.

Since it will take effect on July 1, we have undertaken a public information campaign, Senator, that we are very pleased about. We have produced pamphlets for consumers, and I have enclosed a copy for your information with our statement.

We commend you for your work on that. May I say also that we are going to follow closely on the implementation of this, including regulations, because we want to see it implemented in the way that you intended it to be.

We hope that we can count on your continued support regarding that. But this will not solve the problem of many, many millions of women, and many men, too, will not be able to afford the premiums to continue group coverage or to convert to individual policies when temporary continuation ends.

This law does not apply to small employers. The law is not retroactive, and so it does not help several million women who have already lost their coverage, and it does not help high risk individuals who find that they cannot purchase protection at any price.

OWL particularly endorses the establishment of State pools that market comprehensive health insurance to all residents, regardless of their health status.

Let me say, in general, we support all of the bill, but I would like to talk about affordability in my few remaining moments, if I may.

Senator DURENBERGER. They are very few, the red light is on.

Ms. GLASSE. Then let me give you an illustration, Senator. If I may illustrate the point from your own State of Minnesota, with its 10-year-old risk pool program. For persons age 60 to 64, monthly premiums are $100 per month with $1,000 deductible, and $137 per month with a $500 deductible. Those premiums are the lowest in the country among States with high risk pools, and would be affordable by many uninsured persons. But monthly premiums are over $300 in Connecticut, Indiana, and $375 for $1,000 deductible in Florida. A widow in Minnesota might be able to afford the risk pool, while her sister in Florida would not be able to.

Let me say, in conclusion, that we have included a number of other comments, including some specific proposals that we would like to recommend to make these pools affordable. We stand ready to work with you in support of this bill.

Thank you for this opportunity to share OWL's views.

Senator DURENBERGER. Thank you.

I thank all of you very, very much for your testimony today. I regret the lateness of the hour, but we knew that it was going to be like this.

Gail, thank you particularly for personalizing this testimony today.

Our next panel will be Bob Patricelli, the president of Affiliated Business Group in CIGNA, on behalf of the U.S. Chamber of Commerce; Willis Goldbeck, president of the Washington Business Group on Health; Bert Seidman, director of AFL-CIO's Department of Occupational Safety and Health and Social Security; Don Hansen, president of Precise Products, St. Louis Park, MN, on behalf of the National Association of Manufacturers; and Michael Roush from the National Federation of Independence Businessmen.

Come on up in that order, and we can begin. I thank you all for your patience today. We tried to make this hearing as comprehensive as we could to cover the interest involved, as well as the people.

We will begin with Bob Patricelli. I take it that this is the U.S. Chamber's statement, and you can let a little of you leak into it if you want. You could be here in your own right, and we appreciate your being here.

TESTIMONY OF ROBERT E. PATRICELLI,[1] PRESIDENT, AFFILIATED BUSINESS GROUP, CIGNA CORP., ON BEHALF OF U.S. CHAMBER OF COMMERCE

Mr. PATRICELLI. Thank you, Senator. I am appearing in my capacity as chairman of the U.S. Chamber's Health Care Council, and I will summarize my testimony on the bill in the form of seven points, if I may.

First, the chamber supports the present system of voluntary nondiscriminatory, private health care benefit plans that vary in accordance with the needs and preferences of employees. We believe that employment-based group coverage is the most efficient and cost-effective means for financing health care.

Clearly, the Federal Government has been instrumental in promoting the growth and success of this private sector approach, primarily through tax incentives, but without dictating the terms of these plans.

The chamber continues to support positive incentives as the most appropriate way of promoting employer sponsored health insurance.

Second, and related to that, we support the provision in the proposed legislation which would extend a business tax deduction for health care purchased by unincorporated businesses, which are virtually all small businesses, and the self-employed. This builds on the strength of the voluntary system.

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[1] See p. 253 for Mr. Patricelli's prepared statement.

Third, however, the chamber traditionally has opposed, and continues to oppose State and Federal requirements that mandate plan design. Let me explain why.

Employers face an increasingly complex and costly array of benefit mandates. The number of State mandated benefit laws has increased from fewer than 50 in 1974 to over 600 by 1985. Yet, these mandates work very unevenly because in all instances self-insured plans, which are growing in number, are exempt under ERISA. Moreover, an increasing number of State mandates require that these benefits be offered to all residents irrespective of where the insurance policy is issued. Consequently, employees of multistate employers are covered by different sets of benefits based solely on residence rather than on labor management agreements.

Now, on top of the jungle of State mandates, is a series of Federal requirements which this bill would extend. In short, we are building something of an employee benefit Tower of Babel in which State and Federal governments are shouting at each other, States are quarreling about extraterritorial applications, and employers are left with a costly, confusing, and expensive mess to translate.

Fourth, specifically as to this bill, the proposed Federal mandate to extend coverage to former employees for 4 months, at the employer's expense, closely follows the COBRA continuation of coverage mandate. The imposition of Federal mandates on existing State continuation requirements has already created some confusion, and we feel that enactment of additional Federal mandates at this time will only compound implementation and compliance problems.

Moreover, mandated extension of coverage for laid off workers would impose additional health benefit costs on businesses when they are, in some cases, least able to afford the extra burden, and the adverse economic impact of such a counter-cyclical proposal requires your consideration.

Fifth, so what do we propose instead? Access to basic health benefits should be a national goal. The mandated benefits approach, however, has become too fragmented and haphazard. Rather than continue in an ad hoc manner to address gaps in coverage, we recommend that the Congress conduct a systematic review of access and coverage gaps in a manner that permits an assessment of priorities, alternative strategies, associated costs, Federal and State responsibilities, public and private responsibility, and appropriate Federal incentives.

Employers already dedicate nearly 37 percent of compensation costs to all forms of employee benefits. International competition is forcing many firms to assess labor costs, and consider available mechanisms for reducing those costs, and certain health benefits mandates can increase those costs and force employers to consider benefit tradeoffs.

Employers may offer either less generous health plans, with higher copays and deductibles or, in the extreme, offer no health care coverage. In short, there is likely to be no free lunch. You can't expect employers to simply add to their labor costs without considering cuts elsewhere in those costs.

Finally, on this point, we propose that serious consideration be given to requiring that direct benefit costs and indirect economic effects of pursuing additional mandated benefits be stated in any appropriate legislation. In effect, economic impact analysis to permit the weighing of competing public policy objectives prior to the enactment of legislation.

Senator DURENBERGER. Are you getting near the end, Bob?

Mr. PATRICELLI. Yes, I am, Senator.

Sixth, on risk pools, we have not taken a formal position on the establishment of State risk pools, but we do agree that they are worthy of serious consideration even though they do raise some concerns with regard to additional employer costs.

Seventh, I would say, finally, we are pleased that the bill acknowledges the need to encourage ways to lower health care costs for small businesses. While we are studying the specific provisions of the demonstration grant authority, that provision has our general support.

Thank you, Mr. Chairman.

Senator DURENBERGER. Thank you very much.

Willis.

TESTIMONY OF WILLIS B. GOLDBECK,[1] PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH

Mr. GOLDBECK. Thank you, Mr. Chairman.

I am Willis Goldbeck of the Washington Business Group on Health.

I think that it is important to recognize at the outset that the 37 million people that you point out are a demonstration of the failure of the current methodologies we use to provide health care for the population at large. Business wants a market-oriented competitive system, and we are going to lose this opportunity if we don't figure out collectively how to stop the upward trend of the 37 million, a trend which, if it is not dramatically abated, should hit 50 million very soon.

In looking at your particular bill, we certainly support the tax incentive for the self-employed. Obviously, employers are not desirous of any mandated extended benefits, but we have reviewed our position, one that we have taken consistently for the last 4 years, and can accept the 4-month extension if that is a necessary component of addressing the 37 million person gap in a reasonably dramatic and effective fashion.

The small business demonstration certainly is supportable, and a good idea, although I think, in fact, we basically know what to do. The issue is not how to make it easy for an individual small business to buy insurance, because that is probably an impossibility, but how to aggregate small businesses until they buy with the same market clout as big businesses. We know how to do it. It is not new. It does not require a new study, it requires deciding to do it.

Our priority concern is in the area of the pools, less specifically in the area of the high risk pool for which there is ample evidence that you have to come up with some methodology, but more specifically in the uncompensated pools.

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[1] See p. 262 for Mr. Goldbeck's prepared statement.

This is the question, and Bob addressed it very, very succinctly, about the cumulative impact of mandates. These hundreds of State and Federal mandates are having the impact of causing employers to drop their health insurance right now, exactly the opposite of what Congress would desire.

Therefore, we are of the opinion that if you are going to have any form of mandated financing of an uncompensated care pool, it must not be only for those employers that are already meeting their social obligation. You must, in fact, extend the surcharge to all employers, even those who don't provide health insurance, because otherwise you are delivering a totally clear message—drop health insurance, and let some other bigger employer pick up the tab. That is totally irrational for congressional policy or for business policy.

It is important to recognize that over 50 percent of those indigents are employed. They are not those whom we traditionally have thought of as the poor. Therefore, there is all the less inclination on the part of employer A to subsidize through a new surcharge the competitive advantage of employer B down the block who simply chooses not to provide health insurance.

By aggregating, small businesses can afford health insurance. We have demonstrated that, and a number of other organizations have demonstrated that. Some local chambers have demonstrated that. It is no longer a mystery.

We would not feel it is reasonable to accept what the hospitals want to charge as the amount to be paid, or what they claim to be their costs, since there are now years of evidence that there is no rationality or legitimacy that should be assumed in hospital charges or costs.

The question is, What is needed to actually pay for the care that is actually received by the individual indigent person in a particular instance? That is what has got to be covered by the pool and its surcharge, not simply what some hospital wishes to charge.

Don't design the benefit to provide an incentive for hospital care. Design the incentive for nonhospital care. What you are really heading toward is trying to define a minimum benefit package to make health insurance a condition of employment. That is what the cumulative longer term impact of all of the mandates really is.

If Congress is saying that you want the employer sector to pay for this slice of our social service in America, then it has to be all employers. It can't only be a few who did it voluntarily the first time around. That simply doesn't make any sense.

Let me close by saying that these issues are intimately connected to retirement policy in America, to the absence of long-term care, to the fact that the Government just removed the incentives to prefund retiree medical benefits. Fortunately, on the plus side, your bill S. 2554, would start to provide some of the information upon which one could rationally, in either the public or the private sector, develop a health care data base so that we might move ahead in an informed fashion.

Thank you very much.

Senator **Durenberger**. Thank you, Will.

Bert.

TESTIMONY OF BERT SEIDMAN, DIRECTOR, AFL-CIO, DEPARTMENT OF OCCUPATIONAL SAFETY, HEALTH AND SOCIAL SECURITY

Mr. SEIDMAN. Mr. Chairman, I will summarize my statement, but I ask that my full statement [1] be included in the record.

Senator DURENBERGER. It will be made part of the record as will all the statements of the panel.

Mr. SEIDMAN. The AFL-CIO is pleased to testify today in support of S. 2403, the Improved Access to Health Care Initiative. We, in organized labor, share the committee's concern about the dramatic growth over the past 5 years in the number of citizens without health insurance protection, some 37 million, as well as the shocking increase in those with inadequate coverage, 31 million according to a recent study by the Washington, DC, Government Research Corp., a private research group.

At some point during the year, another 30 million may be temporarily without coverage, and I don't think that we should ignore that group.

The AFL-CIO has long supported the enactment of a national health care system which would make access to basic health care service a right for all Americans. I think that this is what we are all talking about at this hearing. Of all the industrialized countries, except South Africa, only in the United States is health care coverage tied to one's job or other source of income. It is not only when you lose your job that you lose your health care coverage, but if you lose your Medicaid coverage, if you lose your disability coverage, you also lose your health care coverage; these are additional individuals with chronic health care problems locked out of the system because they cannot obtain insurance protection.

Medicaid now covers less than 50 percent of the poor. The very existence of public hospitals and other providers of last resort for those without coverage or with inadequate protection is threatened because of the growing demand on them for uncompensated care, especially for the poor and the indigent.

We commend you, Mr. Chairman, and the other sponsors of S. 2403, for introducing legislation which would help to provide much needed health care for the currently uncovered. However, we do have a number of concerns about the bill.

First, under S. 2403, employees will be required to continue coverage for 4 months after layoff, but that will not help the 25 percent of the unemployed who have been jobless for more than 4 months, most of whom are not getting unemployment insurance either.

Second, we are concerned that public hospitals and other facilities serving a disproportionate share of patients without insurance protection may not receive their fair share of funds from State insurance pools. States should be required to give priority to these institutions.

Third, facilities should be barred from shifting the cost of discounts to large nongovernmental payers onto State uncompensated care pools.

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[1] See p. 271 for Mr. Seidman's prepared statement.

Fourth, the definition of "bad debt," "charity care," and "under-insured" in the bill ought to be spelled out.

Fifth, if Congress intends to allow States to deal with the uninsured and under-insured problem by allowing them to set up a managed system of care, then it should specify what it means by a managed system of care in addition to requiring some basic quality controls to protect the health of potential participants.

The AFL-CIO supports the requirement that employers contribute to a State pool for individuals who cannot obtain insurance protection because they are chronically ill or at high risk of becoming ill, but we want the premiums under such a program and the out-of-pocket payments to be affordable to the people who need the health care, and that can be done, we think, only by a sliding scale.

In addition, it should be clearly spelled out that a State cannot charge higher rates to those individuals with relatively poor medical histories.

Mr. Chairman, we would like to inform you that the AFL-CIO ~~has been~~ working with a group of affiliated unions and consumer organizations to develop a model initiative of our own to address the needs of the uninsured and under-insured. In my prepared statement, differences between S. 2403 and our model bill are spelled out, and at the appropriate time we would be pleased to share this model with the subcommittee and the staff.

We commend the subcommittee for taking the initiative in attempting to improve access to health care services for the uninsured and the under-insured, and we are prepared to work closely with you to achieve this objective.

Thank you.

Senator DURENBERGER. Bert, thank you very much.

Don Hansen, welcome.

TESTIMONY OF DONALD HANSEN,[1] PRESIDENT, PRECISE PRODUCTS, ON BEHALF OF NATIONAL ASSOCIATION OF MANUFACTURERS, ACCOMPANIED BY SHARON CANNER, DIRECTOR OF EMPLOYEE BENEFITS

Mr. HANSEN. Thank you, Mr. Chairman.

My name is Donald Hansen. With me is Sharon Canner, the National Association of Manufacturers' director of employee benefits.

I am president of Precise Products Corp., a small Minnesota manufacturing company employing 44 people. We just began our 31st year in the business of supplying larger manufacturing firms with small precision machine components. As a director of the Minnesota Association of Commerce and Industry, commonly known as MACI, a business organization in Minnesota with over 5,000 member companies, and an affiliate of the National Association of Manufacturers, I serve on the health care cost containment committee, and as chairman of the mandated benefit subcommittee. I will return to Washington in August as a delegate to the White House Conference on Small Business.

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[1] See p. 276 for Mr. Hansen's prepared statement.

Our company is a member of the National Tooling & Machining Association, an industry whose life is being threatened by stiff offshore competition.

I am pleased to be here to share with you my concerns about the Access to Health Care Act of 1986.

Mr. Chairman, I am sure most Americans agree that adequate health care should be available to all of our citizens. This is demonstrated by the large number of employers who provide highly subsidized or completely paid for health care insurance for their employees.

Where small group policies are not economically feasible, organizations such as MACI, various trade and professional associations, and unions offer help in covering small company employees through large group arrangements.

Mr. Chairman, there are several components of the bill that I believe are positive steps in promoting health care protection for a greater number of Americans. Certainly, the tax incentive for self-employed individuals to offer health insurance to their employees is probably the greatest incentive that could be offered.

The imaginative proposal to conduct studies and demonstration projects on ways to lower the health care insurance costs is exciting, and it should stimulate some very constructive thinking in all sectors of our country. There are, however, some troublesome provisions.

The statewide insurance pools may prove to be very costly to employers who have no voice nor control over the possible runaway costs. Federally mandated State programs for funding uncompensated and charity care will likely threaten some of the various State programs which are targeting their resources where they could be most effective.

The extension of employment based health insurance coverage for laid-off employees and their dependents imposes yet another financial burden on employers. We have yet to feel the effects of title X of COBRA that allows employees' former spouses and employees' former dependents to coattail on an employer's plan for 18 months. These people will, of course, have an effect on the group's experience and future costs.

This provision of the bill assumes that all laid-off employees have no money to pay for health care insurance, something which is not true. Severance pay, unemployment compensation, and often accrued benefits, can serve well a former employee until new employment is found.

Precise Products Corp. will spend over $100,000 this policy year on health care for its employees. This is an average for 4 months of $34,400. In an industry staggering under an intense foreign competition and with a net profit average of 1.6 percent in our size category, there are many small shops in the United States who cannot afford any more mandated employee benefits.

As more and more employee health care costs are imposed on employers, the greater the disincentive to hire additional people. The consensus of the National Association of Manufacturers and of MACI members is, please, no more Government-mandated costs.

Mr. Chairman, proper nationwide health care is a societal problem whose solution requires some participation by all of us. I hope that my testimony will help you in your deliberations on the subject, and I thank you for your attention.

Senator DURENBERGER. Thank you, Don, very much.

Mike.

TESTIMONY OF MICHAEL ROUSH,[1] SENATE LEGISLATIVE REPRESENTATIVE, NATIONAL FEDERATION OF INDEPENDENT BUSINESSMEN

Mr. ROUSH. Thank you, Mr. Chairman

I am not an expert on the health care industry or on the insurance industry, therefore, my remarks are going to be primarily directed toward the description of the attitude and operational characteristics of the small business community that are relevant here.

The primary basis for my remarks comes from a national survey we conducted on this subject in late 1985 entitled, "Small Business Employee Benefits." In addition to this and other survey results, we also periodically poll our entire membership on public policy issues. First, I will summarize some of the results of the survey, and then I will briefly discuss the policy implications from the small businesses' point of view.

The number of small business owners providing employee health insurance has been rising—65 percent of firms offer health insurance to at least some full-time employees, which is an 8-percentage point increase from a similar finding in 1978; 42 percent of small businesses provide health insurance to all of their full-time employees. The vast majority of firms, in all size categories, offer plans that include hospitalization, surgical, and major medical. In the aggregate nearly two-thirds of these employers pay the entire premium cost, with smaller firms more likely to pay 100 percent of the cost than larger firms.

Most responsible for this increase in coverage are firms in financial services, professional services, retailing, and smaller firms generally.

Well over 80 percent of health insurance plans offered by small firms carry an option for dependent coverage. However, few part-time employees were provided any health insurance.

The mean health insurance premium paid by small employers was just over $1,700 a month, more than double the monthly premiums paid in 1978. Small business owners purchased private health insurance from a great variety of carriers, but self-insurance and HMO remain an extreme oddity among small firms.

The firm was the group sponsor, more often than not, but trade and business associations have increasingly taken that role. We believe the trend of greater association sponsorship is tied directly to the increased employee health coverage in small firms.

Small business owners or designated employees spend comparatively little time searching for health insurance alternatives, health care cost control options, et cetera. Outside advisors, particularly insurance agents, most often substitute for the employer or the employee search.

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[1] See p. 293 for Mr. Roush's prepared statement.

Employee health insurance is not provided by about one-third of small firms. No single reason dominated their decision, but the most frequently cited reasons were: A large percentage of their employees were covered under a spouse or parent policy—there are a lot of secondary wage earners in small businesses—the premiums were too high, employee turnover was too great, the firm's profitability was insufficient, or the firm couldn't qualify for a group policy.

While small employers will increasingly provide health insurance for their employees, it is unclear just how dramatic this increase will be. The composition of the labor force and the differences in small business profitability will limit growth in the proportion of small business owners instituting and putting in insurance plans.

Coverage will continue to increase as health care costs decline; labor markets accept it as a condition of employment; and as associations make group plans increasingly accessible to the smallest firms.

Blending our survey results with our policy polls, small businesses overwhelmingly oppose any government-mandated health insurance programs or, indeed, any government-mandated minimum insurance coverage. The one-third of small firms which are now not offering health insurance plans are not doing so primarily because of labor market composition problems, and profitability problems, neither of which can be controlled by the small business owners or the Government.

With that, Mr. Chairman, I will just end, and then you can ask me any questions you would like.

Senator DURENBERGER. I am going to have to be brief, I guess, because we are holding everyone's lunch up.

I wonder if I couldn't get a comment or two on what society ought to expect from the employment sector with regard to the health of employees.

Obviously, in various ways, the Government, on behalf of society, addresses, this problem. We have occupational safety and health, and we have environmental legislation. So, in effect, we set some parameters around the behavior of the enterprises as they relate to the health of society, and the specific health of employees.

As we have talked about earlier today, in terms of the economic health of employed persons, we started talking about Wisconsin's unemployment compensation, and then we started the social insurance system in this country. We use tax policy now, as you all know, to set up 401-K's, and 403-B's, and IRA's, you name it. We have section 125 cafeteria plan designs. All of this, I think, is an effort on the part of society in the larger sense, through the workplace, where you are earning your money to provide for your health, and, in some cases, for education, legal services, and Lord knows what else. The line gets longer all the time.

Then, when we come along and make some demands on behalf of society in the form of what you call mandates here, we generate some criticism because we generate too many mandates.

Just concerning the health area, I understand that the States have been doing a lot of mandating of health benefits. You have to put in toothbrushes, you have to put in eyeglasses, you have to put in chemical dependency, and all that sort of thing. It is sort of like you have an exchange for the right to sell insurance in our State, and for this sight you have to give every employee, whether they need it or not, access to toothbrushes, or whatever the State decides is good in general, and I don't believe that the National Government has done that.

The National Government lately has been saying that in exchange for the tax benefits that accrue to the employers for expenditures on behalf of his or here employee's health insurance w would like to see a few things. I will acknowledge, we are just sort of getting started in that area. COBRA was part of it because we had been faced with the 1982 depression, and some of my cosponsors on this bill wanted to go out and spend a whole lot of money creating a new program for health care for the unemployed. We resisted that. We said, the better place to do that is in the employment setting.

Here comes COBRA, and it says, for the widows, and the kids under 21, that are being cut off, maybe we can find some place in the employment setting to spread the base for a small subsidy for their health care.

Now we are talking about 4 months of continuity. We are talking about the contributions that might have to be made in pooling arrangements, and the next thing, I am sure, we will be talking about catastrophic, we might as well all know it.

Some of you have been witnesses before the Finance Committee since before I got there saying that the cheapest way to provide safeguards is, in effect, to mandate catastrophic. You don't need the rest of the stuff if you have catastrophic because you are already paying those people a salary. What you really ought to do is to provide them insurance. Some of you have said that, but not all of you.

One of the distinctions that I am trying to draw here, as we debate mandates is whether you are talking about mandates that say you have to provide a particular kind of coverage or benefit, or something like that, or are you talking about this other kind of mandate which says that in exchange for a tax subsidy for that expense, we expect some good out of that that goes beyond the good that we achieve from your helping your employees?

There might be some risk in my saying this, but if Government pays me $75,000 a year, I don't think that they have to buy me health insurance. I don't think that they have to. I ought to be able to buy that myself. In a world that had only limited resources, I ought to be able to buy that myself. But the Government buys it for me so that it can also buy it for some of my assistants back here who get paid much less than I.

You would acknowledge that the president of a company, unnamed, large corporation executive, may not need $3,300 a year worth of insurance, but the guys on the line wouldn't buy it if you paid them cash. They wouldn't buy health insurance.

So we have institutionalized this arrangement, and yet this arrangement often results in coverage beyond what I really have to have, what I can't buy out of my salary. Even if I am on the line at Chrysler making $35,000 a year, I could contribute some of that to buy health insurance, but I don't because it is much easier to just stick him and everybody else with paying for first-dollar coverage.

I am amazed that two-thirds of small business in this country have first-dollar coverage. Of course, that is what they want.

I don't want to pick on Don, and I was going to send him a little note on that. He is a terrific author, Don Hansen, and he is also president of the Minnesota Tooling & Machine Journal. He wrote this great piece called "A Word From The President" in the February issue of his journal. It is entitled, "Making Tough Decisions." It says: "You are a stockholder of XYZ Co.," and he goes on and on. He describes us in government. He got this from my speeches because this is the way I talk about special interests and Government a lot.

His piece is that folks in government can't ever say, no. Then he holds up Lee Iaccoca, I think, as an example. He says: "In a recent Newsweek column, he suggested that we reward our leader for saying no. Too many of our leaders in Washington seem to have dropped that word from their vocabulary."

He dropped it. He can't say no to the guys who want first-dollar coverage. He can't say it. He can't say no to the fact that everybody wants to have import duties to keep the Japanese cars out of here, so we can keep more autoworkers employed in this country. There are a lot of things that he can't say, no, to either.

So we live in this society in which all of us have trouble at certain times in saying yes to the right things, and no to the right things.

What we are seeking, I think, from this hearing is some guidance on the best way in which the employment sector and the Government can relate to each other on behalf of the 37 million people. If somebody says to me that mandate interference with the relationship between employer and employee, I don't want to get into that one at all.

If you just say I don't like that mandate at all because it might have some costs, then I am going to say I am already subsidizing the rest of your costs, can't I get a little something on behalf of society for that mandate. So can we talk just very briefly about that issue, at least looking at the National Government.

I think what Bert said is a thesis here, and I don't know if you want to disagree with that. When we talk about national health insurance sometimes we get confused, and just the association of my name with Teddy Kennedy's name also gets a lot of people confused.

I think he said something about access that is really important. Do we want to complete that circle or don't we as a nation?

I want to complete the circle, I will be honest with you. I want everybody in the country to have a plastic card. The question is what is the most efficient way to get that card? I know that it is not to have the Government issue the card. I know that it is not to turn everybody into Medicare, Medicaid, or third-option beneficiaries. That is not the way to do it.

What is the best way to do that, really, is the thesis of that bill because unless you disagree with Bert on the access question, it must be a national priority to make sure that every American has adequate medical care and adequate financial protection at a cost that individuals and the Nation can afford.

Mr. **Seidman**. Let me start by saying one thing in response to what you said. The Canadians have a national health care program, and I am not going to talk about the fact that it is a national health care program. But the principle of that program is that every Province must, in return for the funds that it gets from the Federal Government, provide for 95 percent of the citizens of that Province.

The national law went about telling the provinces how to do it to some extent, but not to a very great extent. The Canadian law is written in about 8 or 10 pages, and not in hundreds of pages. All it said was that it is up to the Province to determine how it wants to administer its program, what specific benefits it is going to provide for, what system of financing it is going to use, and so on.

It seems to me that we ought to be moving in that direction. In other words, I don't think that in 1986 or 1987, we can be sitting in Washington and talking about a national health insurance bill which provides everything in great detail. But it seems to me that the principle that is involved here, that nobody at this table seems to disagree with, is that we ought to be able to set up a system that will make it possible for everybody to have access to health care. You can't do it entirely through the employment system, because there are too many people who, for one reason or another, are out of the employment system. Many of them want to be in the employment system, but they are out against their will, and they are not people who can afford to pay for decent health insurance even if they receive unemployment assistance, and only one-third of the unemployed do, and when they receive unemployment insurance it amounts to an average of only one-third of their previous wages.

You can't buy much health insurance when your income has been cut to that extent. You have too many other obligations. So it seems to me that what we ought to start with is to accept the principle of universal coverage and then go on to see what specific groups there are who are uncovered and how do we deal with each of them.

I agree with these gentlemen when they say that you have to do something about employers who are not providing anything now. One way of doing that is by spreading the costs, and everything that we are doing now is in just the opposite direction.

Employers are insisting that they want to pay only for the cost of their own employees. They don't want to take on any of the social costs.

Another way is the way that John Byrne, who at one time was the ranking minority member of the Ways and Means Committee, suggested many years ago for the Nixon health insurance plan, and that is to gradually require a certain percentage of payroll from employers for this purpose, rather than to load it on them all at once.

It seems to me that you are bound to arouse political opposition if you require employers, all at once, to assume a very significant cost that they have not assumed up until now. I think that we have to begin working at this first by accepting the principle that we do want to get coverage for everybody, and then examine very closely who it is who does not have coverage, and how we can go about assuring them coverage.

Senator DURENBERGER. Anybody else?

Mr. PATRICELLI. Mr. Chairman, I think that we are going to find ourselves in some agreement here on the panel on the need for a broader look. I like the old expression that says that when you don't know where you are going, any road will get you there.

You, yourself, have said, what we need is some national policy, and you have identified where you stand on that. We need to decide whether we believe, as a society, in universal financial access to health care. If we do, what kind of health care; managed health care? If we do, what is the split of responsibility between the public and the private sectors. Big parts of this bill raise that question and also the split of responsibility between Federal and State governments.

I think that what we are objecting to on behalf of the chamber is the piecemeal approach without the philosophical and conceptual underpinnings that tell us where we want to go.

Finally, as to your point about the difference between tax incentives at the Federal level, and the benefit plan mandates at the State level, I would say, personally, it is mostly a distinction without a difference for the great majority of employers who are providing health benefit plans, conditions on the availability of the Federal tax deduction amounts to a mandate.

Mr. GOLDBECK. I think we certainly would want to be on record as saying that the objective is to close the circle in some reasonable fashion. I don't propose to say that we know precisely how to go about it, but it is certainly in an employer's enlightened self-interest and basic economic interest to have the smallest possible portion of our Nation in any poverty status.

Reduced poverty and increased capacity to purchase insurance is obviously of tremendous value to the medical care industry, which is not a small piece of business in the United States. It is also of tremendous value to virtually every member of our organization. If increasing numbers of people can't even buy their own health insurance, they are certainly less valid consumers for a great many other things.

You paint a strikingly logical picture when you talk about how we should just look at the tax incentive employers and employees receive, and say there should be a price for that.

If you can get your fellow Senators up there to apply the same degree of logic and rationality, the business community could provide a more coherent response. That process is not taking place, so we are not in a position to say, here is the tax benefit, and here are the four logically constructed tradeoffs against the tax benefit.

Bob articulated it very well. There have already been 600 State initiatives to capture that tradeoff. You have one set, and somebody else has another, and they are empassioned loyalists for getting at that same tradeoff rationality for a lot of other objectives. We only get the chance to deal with these one at a time, and that lessens the cohesiveness that you might like to have from the private sector respondee.

One trend is important for you to know: The big companies that I deal with are more and more inclined to accept the idea of a Federal mandate that has uniformity associated across the States and supersedes State mandates. This is preferable to trying to figure out how to deal with the conflicts among different levels of governance in America.

Many companies will say, politically, that they don't like Federal involvement. But a comprehensible Federal rule that applies to all of them equally across the country is better than the hodgepodge of conflicting requirements that exists today.

Senator DURENBERGER. Don.

Mr. HANSEN. First of all, Senator, I think that it should be noted that you originally stated the question and directed it toward, I think you used the term, private employer or something like that. As I go through the list of the 20 witnesses here, I believe that I am the only business person here who signs the checks, who actually has people employed other than in the health care field.

I want to note that when I go to these other meetings in the State of Minnesota the ratio is about the same. I don't know why that is, but perhaps it is because we are so busy trying to tend the store and keep the door open that we haven't got time to do some of these other things which are very important, too.

Be that as it may, the poster up here is interesting in that it is kind of dramatic, but I think the most important thing is to piece these two posters together and note that a good share of the 153 million people who are employed and covered by insurance are covered by their employers' programs.

So when we look over here, it is important to think that we have the $12,000 a year, the $20,000, and the $40,000 a year person getting the tax break, which we all are as employees of our corporations, and we are getting the tax break, and the self-employed person is not. I think that this is one of the areas that your bill is attempting to offset so that we get that part of the circle completed.

I think that it is important that if 153 million of us benefit from a tax break, the rest of the country should also. I agree 100 percent with you that where we possibly can, we should pay our own way. Fifty years ago, when my father was raising me, this was the philosphy in the State of Minnesota and in the State of Wisconsin, where I also lived. Somehow, we, as a society, have allowed ourselves to believe, for whatever reason, that we don't have to do that, somebody will take care of us, whether it is our employer, whether it is the State government, or the Federal Government, or our favorite charity.

Perhaps, in the years that I have been in business, we have been too generous with our employees because we pay 100 percent of their costs of health care, which this year will average $2,400 a year per employee, which is a high number. Last week, my accountant reminded me, as it related to another matter, that your benefits are 50.5 cents per dollar of payroll. I said, "That is too high." and he said, "you are right, it is too high when the national average is somewhere around 33 percent or something like that."

Senator DURENBERGER. For Germany, Japan, or some other of your competitors?

Mr. HANSEN. I am talking about this country. You can push a lot of numbers around, but I think that 50.5 cents per dollar is quite high. It is now having its effect on our company. I don't know how I am going to go back to our employees and say, "Somehow or other, you are going to have to pick up the added cost of your health insurance." I have been warning them about this, and this is going to have to come.

I think that this is a part of the life cycle that we have to learn to live with, that this year can't be guaranteed to be better than last year, next year won't necessarily be better than this year. This is the way life is, and we have to accept this. We certainly have to accept this when we run our businesses. We have to accept this when we are employees.

I think that whether we have a paternalistic attitude in a nonunion operation, or in a bargaining situation with a bargaining agent, we have to remember that out of the pie that is represented by a corporation, there are only so many slices that you can cut out of the pie unless you can force that pie to be larger.

In this country, we are finding out, particularly in the manufacturing sector, that the pie is actually shrinking. This is not very much fun. It is not very much fun to be an employer, and it is certainly even less fun to be an employee who is no longer working.

Even those people who are working, we have to face reality that we can't afford $20 an hour wages and benefits in this country when we are competing against people who are perhaps working for one-fourth of that, or whatever some of these other numbers are.

I think that we have to look at this as a broad picture. It certainly appears to me that private industry has done a fairly good job in supporting health care in this country. I guess I don't want to see the burden of closing the circle laid entirely at the foot of the employers because, like in our trade association, 1.6-percent profit marging is not very much.

I don't think that very many people, if our company was a public corporation, would want to invest in our company. We can't make enough money to satisfy the people who want to clip the coupons when they retire, they have to have income. All of our retirement programs are based on making some money on investments, and those investments are invariably in private corporations, and certainly we have to have healthy corporations in order to carry some of these costs.

Senator DURENBERGER. Thank you.

Mike, do you have a wind up.

Mr. ROUSH. I have basically two comments, paralleling Mr. Hansen's comments.

I think that we have to recognize some realities. You may want to have employees covered on the job but there are those employers who will not be able to do so, particularly small employers. As I pointed out, labor market composition problems and profitability problems will have to be faced.

It has been mentioned by some that the European example of benefits and coverages is one the United States should copy. I think that would be a mistake since Europe has not created any net new jobs since 1975. Is it the moral obligation of employers to create jobs and employment, so that people can afford these things themselves, or is it the employer's or Governments, obligation to directly pay for these things?

If you make the decision to go ahead and mandate these things, there are a number of practical problems which I briefly touched on in my testimony that need to be addressed particularly for small employers. Are we going to make small employers into social bureaucracies, funneling paperwork and notification requirements? What will happen is that you will drive them underground.

Senator **DURENBERGER**. Gentlemen, thank you all very much. I appreciate your testimony and your patience also.

The hearing is adjourned.

[Whereupon, at 12:55 a.m., the subcommittee adjourned, subject to the call of the Chair.]

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Prepared Statement of Gail R. Wilensky

Mr. Chairman, thank you for inviting me to testify before the Subcommittee on Intergovernmental Relations. My name is Gail Wilensky. I am the Vice-President of Health Affairs at Project HOPE. I am here, however, as an independent health policy analyst and not as a representative of Project HOPE. The purpose of my presentation is to review some of the problems of the uninsured in a competitive environment, to suggest the types of strategies which would improve access for this population and to relate these strategies to the various provisions of S.2403.

Access To Care In A Competitive Environment

The problems of the uninsured and the problems of uncompensated care are not new problems. Why then have they been receiving so much attention? The most frequent answer is that the number of uninsured has increased, at least moderately and perhaps substantially, and that the amount of uncompensated care has been growing. While these responses are true, the most important reason for the increased attention being given to the uninsured and uncompensated care is not the increased number of uninsured but rather the change in the financial environment of the health care industry.

The 1980s has been characterized as the period of the "prudent buyer." All of the major purchasers of health care--the federal government, state and local governments, and most importantly the private sector--have concentrated on paying only for what they buy and getting the best price for their purchase. The result has been a shift from implicit to explicit financing. Items such as uncompensated care, which were once financed implicitly, that is by cross subsidy, have thus been placed at risk. While the list of items that use to be implicitly financed includes more than the care of the uninsured, the problems of the uninsured and of uncompensated care represent the most visible and troubling negative consequences of our move to a more competitive environment.

Uncompensated Care Versus The Uninsured

We hear much about uncompensated care, the providers way of looking at the problem. Looking at it in these terms indicates that it is indeed not a trivial problem. In 1978, uncompensated hospital care was estimated to be between $4.2 billion and $5.2 billion. By 1982, it had grown to $6.2 billion, by 1983, $7.8 billion, and estimates for 1984 indicate that uncompensated hospital care reached $9.4 billion. While public hospitals and teaching hospitals, particularly urban teaching hospitals, have experienced disproportionately large amounts of uncompensated care, all hospitals can be expected to experience increased difficulty in handling the problems of the uninsured as the health sector becomes more competitive.

The problem, however, is not just uncompensated care--or who should pay for those receiving care who either do not or cannot pay for that care--but more broadly, the care of the uninsured in a competitive environment. Measures of uncompensated care understate the problem because they only measure the effect of those who have actually gained access to the system. All of those who, for some reason, are left out of the health care system, or who keep themselves out of the health care system because they lack financial resources, never generate uncompensated care and are therefore uncounted in measures of uncompensated care. Research has shown that the uninsured are not only vulnerable financially, but medically as well. The uninsured systematically use less medical care than the insured population, even when they are sick, and are less likely to seek care as well (Wilensky and Berk, 1982; Robert Wood Johnson Foundation, 1985). Thus, it is not just a question of "who pays" for the uninsured but of ensuring the uninsured have reasonable access to health services.

Who Are The Uninsured?

According to the best information we have available, there were about 25 or 26 million uninsured on average in any year in the United States from the mid 1970s through 1980. There is some dispute as to how much that number increased during the recession, with estimates as low as 29 million and as high as 34.5 million by 1983. There is also substantial dispute about the number of uninsured in 1984. The number of uninsured reported by the Survey of Income and Program Participation (SIPP) as of the second quarter 1984, was 30.4 million individuals, down from 34.5 million in 1983 (unpublished data~~, SIPP)~~. The number of uninsured in 1984 according to the Urban Institute was approximately 35 million (*Wall Street Journal*, June 3, 1986). The numbers cited in the Congressional Record and based on unpublished data from the Current Population Survey is 37 million, up from 35 million. These are large discrepancies in data and it is important to understand why the discrepancies have occurred and how the various data sets relate to each other. The most relevant fact to keep in mind, however, is not the 30 versus the 37 but that it will become increasingly more difficult for the uninsured to obtain care in our current financial environment. It is thus a major problem for 30 million uninsured; it is an even more serious problem if there are 35 to 37 million uninsured.

Despite the dispute in the absolute numbers of the uninsured, the characteristics of the uninsured appear surprisingly stable from survey to survey:

--About half of the uninsured are employed, either full year or part year; when their dependents are included, the employed uninsured account for abut three quarters of the uninsured population;

--While 35 tc 40 percent were in families who are poor, at least one third were in families whose income was twice the poverty line;

--Almost 90 percent of the employed uninsured worked for employers who did not offer insurance coverage.

Strategies For Improving Access To Insurance And Access To Care

There are a variety of strategies which can be used to address the problems of the uninsured. It is helpful to consider the various subgroups among the uninsured and the strategies which are most appropriate for these subgroups.

The Medically Uninsurable

There are a small group of individuals, sometimes estimated to be about one-half of one percent of the population, who are unable to obtain insurance because of pre-existing medical conditions. This group is often referred to as "medically uninsurable." One approach which has been adopted by a variety of states, including Indiana and Minnesota, is to establish an insurance pool which makes insurance available to these individuals at what is deemed "affordable rates." Section 2 of S.2403 defines the minimum standards for a health insurance pooling association, that is, it sets limits on annual out-of-pocket expenses for covered services, deductibles, lifetime limits, and premium rates. It also finances the losses associated with the pool, caused because the resulting package is priced below the market rate, by assessing all of its participating members equally. The pool is financed by employer contributions to the pool. Any employer who does not voluntarily participate in the pool will be assessed a 10 percent excise tax on the employer's health benefit expenses. Given that self-insured employers might otherwise not choose to be part of the pool, and could not be forced to be part because of ERISA, the excise tax component is an important provision.

The concept of an insurance pool for the medically uninsurable is an appropriate mechanism for dealing with this particular problem. Requiring that the losses associated with the pool be financed by a tax on employers is questionable. While employers represent one potential tax base, it can be easily argued that other tax bases are not only possible but indeed preferable. In general, the broadest possible tax base is the most appropriate for making up the losses associated with the uninsurable population. This could be a surtax on the income tax, a portion of the sales tax or a value added tax. It could also be financed by a specific excise such as a luxury tax or even a tax on restaurant meals. If the tax is to be assessed either on insurance premiums or on employers, however, it is critical that a mechanism be found to tax the self-insured employers. The mechanism included in Section 2 does accomplish this goal.

The Employed Uninsured

The characteristics of the uninsured indicate that any policies which make it more likely that the employed uninsured obtain insurance coverage have the potential of dramatically affecting the number of uninsured in the population. Statistics from a variety of surveys have indicated that small firms are much less likely to offer health insurance than larger firms and that employees working for small firms are less likely to be insured than employees working for larger firms. There are several reasons cited by a recent National Federation of Independent Businessmen Survey as to why small employers are less likely to offer health insurance coverage such as the high cost of insurance and high turnover rates. The inability of some firms to use pretax dollars to purchase health insurance, however, is clearly one very important reason.

Under current tax law, the self-employed and the owners of unincorporated businesses cannot deduct the premiums for their own health insurance plans. This not only means that the self-employed and owners of unincorporated businesses are less likely to be covered by health insurance, but it also means that their employees are less likely to be covered as well. While it can be argued that our current method of subsidizing the purchase of health insurance by excluding employer-provided health insurance from the employees taxable income is not the most equitable means of subsidizing the purchase of insurance, there is little justification for not allowing certain segments of the employed population the same tax subsidies enjoyed by the rest of us. Section 5 of S.2403 allows self-employed individuals to take a business deduction for health benefits as long as the individual provides health insurance coverage to his or her employees and thus corrects the current inequity regarding unincorporated businesses and self-employed individuals.

There are other strategies which states could adopt to make it more likely that small employers provide health insurance coverage such as assisting in the formation of multiple employer trusts, establishing administrative intermediaries to assist firms facing high labor turnover, and promoting the use of rural cooperatives as purchasers of health care. While some financial support from the federal government to assist in these activities would be helpful, none of these mechanisms in and of themselves represent major public sector financial commitments.

Employees and their dependents who continue not to be offered employment related insurance, despite the efforts of the state to encourage employers to do so, should also be offered the opportunity to use pretax dollars to purchase their health insurance. A mechanism which permits this was included in S.2484, the Uninsured Workers Health Insurance Act of 1986, introduced by Senator Durenberger on May 21.

The Unemployed Uninsured

Because health insurance is so frequently associated with employment, there has been substantial concern about the loss of insurance coverage when an individual becomes unemployed. Section 4 of S.2403 addresses this issue by requiring employers to maintain their contribution to the health benefits of the laid off employee for a period of up to four months. It also requires that employers provide their employees with an open enrollment period whenever the employee's spouse has lost employment and the family was covered only by the former employee's health benefit program.

Since most unemployed are unemployed for a period of less four months, Section 4 clearly addresses the problem of insurance loss for the unemployed. It does so, however, in a way which is "procyclical" that is, it exacerbates the financial problems of employers who are already facing financial difficulty. There are several other strategies which could be used to address the problems of the uninsured unemployed. The approach I would prefer is the one included in S.2484 which makes a tax credit available to all individuals who are not offered employment related insurance, including the employed uninsured and the unemployed uninsured. This seems to be the most equitable treatment for the unemployed vis-a-vis the employed population receiving employment provided insurance coverage and the employed population not receiving insurance coverage. A second strategy would be to have employers contribute funds into a state administered pool based on their payroll and unemployment experience with the pool providing a catastrophic insurance plan for unemployed individuals for a period of four months. The advantage to a strategy of this nature is that it is countercyclical rather than procyclical. The purpose for providing only a catastrophic insurance plan rather than previously provided health benefits is to protect the unemployed worker from financial disaster due to an unexpected medical catastrophe at the lowest possible expense to the employer. The use of a catastrophic plan should also lower the likelihood of excessive use of health services by individuals who have substantial amounts of free time and not provide potential disincentives to the search for new employment.

The Remainder Of The Uninsured

While the employed and unemployed uninsured and their dependents account for approximately three quarters of the uninsured population, there remains 25 percent of the uninsured population who will not be reached by employment related strategies. Since most of these people are below the poverty line, the likelihood is that they would not be helped sufficiently even if a refundable tax credit were introduced. These individuals need to be assisted by public sector resources either directed toward providers or toward an insurance based program. There are a variety of mechanisms which can be used such as direct grants to public hospitals, payments to other providers, expansion of Medicaid, introduction of a voucher system or other means. The major requirement for all of these strategies, however, is the need for additional resources. Language contained in Section 5 is helpful insofar as it recognizes the problem and attempts to tie some existing federal resources to the solution of the problem. It, however, must be recognized that Section 5 primarily involves exhortation, reflecting a federal commitment to help solve a problem without any additional resources.

Conclusion

There are several sections of S.2403 which could substantially improve the access to insurance of at least some portions of the uninsured population. The single most important provision is Section 5 which allows the self-employed and unincorporated business owners to deduct their own health insurance premiums, provided they also extend coverage to their employees. To the extent that employers do not offer health insurance because they cannot use pretax dollars for their own coverage, this provision will increase the likelihood that some of the employed uninsured are provided with health insurance coverage. Section 4 will provide insurance coverage to the unemployed uninsured for a period of four months but will do so at the risk of exacerbating the financial plight of employers who are already facing financial distress; there are other ways to accomplish part of this goal. Section 2 will make insurance available to those who are "medically uninsurable." This is a very small portion of the population but one which is financially vulnerable to catastrophic loss. Section 2 is financed by an assessment on employers; there are other funding mechanisms which could also be considered.

S.2403 will not solve all of the problems regarding the uninsured in a competitive environment. Nor, as indicated above, do I agree with all of its provisions. It does, however, contain several provisions which would make important contributions to resolving the current problems of the uninsured. Competitive trends initiated by prudent buyers and cost conscious initiatives will make it increasingly more difficult to provide care for the uninsured and underinsured. Doing nothing is not an option.

Prepared Statement of Aaron K. Trippler

SENATOR DURENBERGER AND MEMBERS OF THE COMMITTEE:

MY NAME IS AARON TRIPPLER AND I AM NATIONAL LEGISLATIVE PUBLIC RELATIONS DIRECTOR FOR COMMUNICATING FOR AGRICULTURE. I APPRECIATE THE OPPORTUNITY TO APPEAR BEFORE THIS COMMITTEE AND PROVIDE TESTIMONY IN SUPPORT OF ESTABLISHING STATE INSURANCE POOLS FOR INDIVIDUALS WHO DO NOT HAVE ACCESS TO ADEQUATE HEALTH INSURANCE COVERAGE BECAUSE THEY HAVE PRE-EXISTING HEALTH CONDITIONS, AS WELL AS ATTEMPTS TO INCREASE ACCESS TO HEALTH CARE FOR ALL AMERICANS.

BEFORE I BEGIN, I WOULD LIKE TO TAKE THIS OPPORTUNITY, SENATOR DURENBERGER, TO THANK YOU FOR YOUR LEADERSHIP ON BEHALF OF THE MILLIONS OF AMERICANS, BOTH IN URBAN AND RURAL AMERICA, PREVIOUSLY DENIED THE OPPORTUNITY TO FIND ADEQUATE INSURANCE PROTECTION. YOUR LEADERSHIP IN INTRODUCING THIS LEGISLATION IS A CRITICAL ONE IF WE ARE TO BEGIN SOLVING SOME OF TODAY'S HEALTH CARE PROBLEMS. WE APPLAUD YOUR EFFORTS. THANK YOU FOR CARING.

COMMUNICATING FOR AGRICULTURE, WITH NATIONAL HEADQUARTERS IN MINNESOTA, IS A NATIONAL, NONPROFIT, NONPARTISAN ORGANIZATION DEDICATED TO PRESERVING THE RURAL WAY OF LIFE IN AMERICA. OUR MEMBERSHIP IS COMPOSED OF FARM AND RANCH FAMILIES AND SMALL AGRI-BUSINESSES IN OVER FORTY STATES. WE CONSIDER OURSELVES IN ADDITION TO, NOT IN PLACE OF, ANY OTHER RURAL ORGANIZATION AND WORK TO ACCOMPLISH OUR GOALS IN A POSITIVE WAY.

THE FOUNDATION FOR CA WAS LAID IN THE MID 60's BY A GROUP OF MINNESOTA DAIRY FARMERS AND CREAMERY OPERATORS WHO HAD A COMMON GOAL: THAT RURAL PEOPLE SHOULD HAVE SOME OF THE BENEFITS, PROTECTION AND REPRESENTATION THEIR CITY COUSINS ENJOYED. THIS INCLUDED THE OPPORTUNITY TO BE ADEQUATELY COVERED BY HEALTH INSURANCE.

INCORPORATED IN 1972 AS THE CREAMERY ASSOCIATION, CA AWARDED SCHOLARSHIPS TO STUDENTS PURSUING CAREERS IN AGRICULTURE AND AGRIBUSINESS, ASSISTED ITS MEMBERS WHEN THEY NEEDED HELP WITH GOVERNMENTAL AGENCIES AND LOBBIED FOR BETTER HEALTH CARE LAWS IN MINNESOTA.

IN 1977, THE GROUP BECAME A NATIONAL ORGANIZATION AND CHANGED ITS NAME TO COMMUNICATING FOR AGRICULTURE. CA BELIEVES STRONGLY IN THE IMPORTANCE OF PRIVATE HEALTH CARE AND INSURANCE SYSTEMS. ONE OF THE FIRST RESOLUTIONS CA MEMBERS ADOPTED, AND HAVE REAFFIRMED EACH YEAR, STATES THAT "HEALTH CARE AND HEALTH INSURANCE ARE BEST ADMINISTERED AND MAINTAINED BY THE PRIVATE SECTOR, WITH A MINIMUM OF GOVERNMENT INTERFERENCE AND WITH LEGISLATION ENACTED ONLY TO INSURE THAT ALL AMERICANS ARE GUARANTEED A MINIMUM STANDARD OF HEALTH INSURANCE AT A REASONABLE COST, REGARDLESS OF HEALTH OR AGE; AND THAT HEALTH CARE CHARGES SHOULD BE SUBJECT TO RATE REVIEW COMMISSIONS TO BE ADMINISTERED BY THE STATES".

THE REASON FOR CA'S INVOLVEMENT IN THIS ISSUE IS VERY SIMPLE. A MAJORITY OF OUR MEMBERS ARE INDEPENDENT BUSINESS PEOPLE, WHETHER FARMERS, RANCHERS OR MAIN STREET MERCHANTS. AS SUCH, THEY DO NOT QUALIFY FOR GROUP INSURANCE COVERAGE SUCH AS THAT PROVIDED BY EMPLOYER-EMPLOYEE GROUPS. IN SUCH INSURANCE GROUPS, HEALTH QUESTIONS AND PHYSICALS ARE USUALLY WAIVED.

THIS IS NOT TO SAY THAT THESE INDIVIDUALS DO NOT HAVE ANY ACCESS TO GROUP HEALTH PLANS. MANY ASSOCIATIONS PROVIDE SUCH HEALTH PLANS AS BENEFITS TO THEIR MEMBERS. HOWEVER, THE INSURANCE COMPANIES OFFERING THESE ASSOCIATION PLANS USUALLY REQUIRE HEALTH QUESTIONNAIRES AND PHYSICALS TO BE COMPLETED. IF APPLICANTS TO THESE HEALTH PLANS HAVE A PRE-EXISTING CONDITION, THAT CONDITION MAY BE RIDERED, RATED, OR THE PERSON MAY BE REJECTED FOR INSURANCE COVERAGE.

THE CITIZENS OF THIS COUNTRY WHO NEED THIS TYPE OF PROGRAM ARE PEOPLE WHO ARE SELF-EMPLOYED, SUCH AS FARMERS AND SMALL BUSINESS PEOPLE. THEY HAVE TREMENDOUS DIFFICULTY IN OBTAINING ADEQUATE COVERAGE. MOST OF THESE PEOPLE HAVE A TRADITION OF STANDING ON THEIR OWN AND ARE PROUD TO PAY THEIR OWN WAY, PEOPLE WHO WANT TO BE FINANCIALLY INDEPENDENT OF GOVERNMENT ASSISTANCE. ALL THEY ARE ASKING FOR IS THE OPPORTUNITY TO PURCHASE ADEQUATE HEALTH INSURANCE PROTECTION. IF THEY HAVE A PRE-EXISTING HEALTH CONDITION THIS OPPORTUNITY IS OFTEN DENIED.

IN ADDITION TO THOSE INDIVIDUALS WHO ARE SELF EMPLOYED, MILLIONS OF OTHER AMERICANS THROUGHOUT ALL WALKS OF LIFE ARE OFTEN DENIED COVERAGE DUE TO PRE-EXISTING HEALTH CONDITIONS, SOME ACQUIRED AT BIRTH.

DURING THE PAST THREE YEARS, CA HAS SURVEYED OUR MEMBERSHIP IN FIVE STATES ON THE QUESTION OF HEALTH CARE COVERAGE. APPROXIMATELY 10% OF THE RESPONDENTS STATED THAT THEY OR A MEMBER OF THEIR IMMEDIATE FAMILY HAD BEEN DENIED HEALTH INSURANCE COVERAGE BECAUSE OF PRE-EXISTING HEALTH CONDITIONS. 9% ALSO STATED THAT THE COVERAGE AFFORDED UNDER THEIR PRESENT HEALTH INSURANCE POLICY WAS RESTRICTED BECAUSE OF A SPECIFIC HEALTH CONDITION.

BUT THERE IS NO NEED TO TAKE ONLY CA'S WORD ON THIS ISSUE. LET ME QUOTE FROM A RECENT STUDY. LOUIS HARRIS AND ASSOCIATES LAST YEAR CONDUCTED A SURVEY FOR THE ROBERT WOOD JOHNSON FOUNDATION IN PRINCETON, NEW JERSEY. THE SURVEY FOUND THAT 6.5 MILLION AMERICAN FAMILIES, OR 9% OF ALL AMERICAN FAMILIES, HAVE AT LEAST ONE FAMILY MEMBER WITH A SERIOUS ILLNESS.

THE SURVEY ALSO FOUND THAT ABOUT 12% OF THE AMERICAN POPULATION, OVER 28 MILLION AMERICANS, HAVE DIFFICULTY OBTAINING ADEQUATE HEALTH CARE. THIS GROUP INCLUDES 9 MILLION OF THE POOR, 2.3 MILLION OF THE UNEMPLOYED, 2.6 MILLION HISPANIC, 2.5 MILLION BLACK, AND THESE CATEGORIES DO NOT INCLUDE THE MEDICALLY DISADVANTAGED.

THESE STATISTICS ARE ALARMING, AS WELL AS THE FACT THAT HEALTH CARE COSTS HAVE INCREASED MORE THAN 250% SINCE 1967 ACCORDING TO THE U. S. BUREAU OF LABOR STATISTICS. IN ADDITION TO THIS, THE HEALTH INSURANCE ASSOCIATION OF AMERICA HAS STATED THAT THE AVERAGE COST OF A SEMI-PRIVATE HOSPITAL ROOM IN 1985 WAS $213, UP 5% FROM THE PREVIOUS YEAR, AND UP 20% SINCE 1982.

THE LEGISLATION BEFORE YOU ADDRESSES MANY DIFFERENT ASPECTS OF INCREASING THE AVAILABILITY OF HEALTH CARE TO ALL AMERICANS. HOWEVER, CA'S PRIORITY IN THIS LEGISLATION PERTAINS TO THE ASPECT OF INCENTIVES TO CREATE STATE HEALTH INSURANCE POOLS.

AS I MENTIONED EARLIER, CA's INVOLVEMENT IN THIS ISSUE GOES BACK TO 1975 WHEN WE SUCCESSFULLY PUSHED FOR ONE OF THE FIRST STATE HEALTH POOLS IN THE STATE OF MINNESOTA.

AT THE BEGINNING OF 1985, SIX STATES (CONNECTICUT, FLORIDA, INDIANA, NORTH DAKOTA, MINNESOTA AND WISCONSIN) HAD ADOPTED SUCH POOLS TO PROVIDE THE OPPORTUNITY FOR HEALTH CARE TO THEIR CITIZENS. SINCE THEN, WE HAVE BEEN SUCCESSFUL IN PASSING THIS LEGISLATION IN AN ADDITIONAL FOUR STATES.

NEBRASKA AND MONTANA PASSED THE LEGISLATION IN 1985, WITH THE POOLS SCHEDULED TO BECOME OPERATIONAL LATER THIS YEAR. IN 1986, IOWA AND TENNESSEE ADOPTED THE LEGISLATION CREATING SUCH POOLS.

SINCE 1984, APPROXIMATELY TWENTY STATES HAVE SERIOUSLY CONSIDERED THIS LEGISLATION. I AM CONFIDENT STATING THAT SUCH LEGISLATION WOULD HAVE BEEN SUCCESSFUL IN MANY OF THESE STATES IF IT WERE NOT FOR THE INEQUITY OF ASSESSING MEMBERS OF THE POOL, MEANING THE EXCLUSION OF SELF INSURANCE GROUPS DUE TO THE FEDERAL EXEMPTION CAUSED BY ERISA.

PASSAGE OF STATE HEALTH INSURANCE POOLS FOR CITIZENS PREVIOUSLY DENIED THE OPPORTUNITY TO PURCHASE COVERAGE IS A SOLUTION THAT WORKS. OVER 20,000 INDIVIDUALS IN THE FIRST SIX STATE POOLS ARE NOW COVERED BY HEALTH INSURANCE.

WHILE PREMIUMS FOR THESE INDIVIDUALS RUN APPROXIMATELY 25 TO 50 PERCENT HIGHER THAN STANDARD PREMIUMS, MOST INDIVIDUALS FIND IT TO BE A SMALL PRICE TO PAY FOR ADEQUATE COVERAGE.

YES, POOLS COULD PROVIDE COVERAGE FOR MANY MORE INDIVIDUALS IF PREMIUMS WERE REDUCED. SEVERAL STATE POOLS HAVE ATTEMPTED TO KEEP PREMIUMS LOWER BY ALLOWING LOW-RISK INDIVIDUALS TO ENTER THE POOL THROUGH PROGRAMS SET UP TO SUBSIDIZE A PORTION OF THE PREMIUM COSTS. ONLY TIME WILL TELL IF THESE ATTEMPTS SUCCEED IN EXPANDING THE POOL TO A BROADER BASE OF THE POPULATION.

HOWEVER, ONE SHOULD BE AWARE THAT POOLS WERE CREATED NOT TO SOLVE THE ENTIRE UNINSURABLE PROBLEM, BUT RATHER TO ASSURE ALL CITIZENS WITH THE RIGHT TO PURCHASE COVERAGE.

POOL COVERAGE IS NOT FOR THOSE WHO COULD NOT AFFORD HEALTH INSURANCE COVERAGE IN THE FIRST PLACE, SUCH AS THE POOR OR UNEMPLOYED, THOSE WITHOUT ADEQUATE INCOME TO PAY THE PREMIUMS.

YOUR LEGISLATION TO CREATE INCENTIVES FOR STATE HEALTH POOLS IS NEEDED. THE ERISA EXEMPTION FOR SELF INSURERS HAS INDEED CREATED AN OBSTACLE TO THE CREATION OF MORE STATE HEALTH POOLS.

THE EXEMPTION PROVIDED BY ERISA HAS PLACED AN UNFAIR BURDEN ON MANY INSURANCE CARRIERS. THEY STATE, AND RIGHTLY SO, THAT MANY SELF INSURERS HAVE AN ADVANTAGE BY NOT HAVING TO CONTRIBUTE TO A STATE HEALTH POOL. HOWEVER, WHILE MOST STATES ALLOW A PREMIUM TAX CREDIT FOR ASSESSMENTS TO THE POOL, THE COST TO REGULAR INSURANCE CARRIERS IS MINIMAL.

CA HAS LONG BELIEVED THAT STATE HEALTH POOLS ASSIST IN KEEPING INSURANCE PREMIUMS TO CONSUMERS AROUND THE STATE AT A MORE AFFORDABLE LEVEL. MEDICAL CARE FACILITIES ARE ASSURED OF COMPENSATION FOR TREATMENT RENDERED. INDIVIDUALS WITH COVERAGE ARE LESS LIKELY TO BE FORCED INTO BANKRUPTCY DUE TO HIGH MEDICAL BILLS, A STATISTIC THAT WAS BROUGHT OUT IN 1976 DURING HEARINGS ON THE MINNESOTA PROPOSAL.

CA BELIEVES THAT STATE HEALTH POOLS CAN ACTUALLY BE A REVENUE NEUTRAL COST TO THE STATE. LET ME EXPLAIN. CONSIDER, THAT IF AN INDIVIDUAL IS COVERED BY HEALTH INSURANCE, THERE IS LESS CHANCE THAT A LOCAL GOVERNING UNIT OR THE STATE WILL HAVE TO DIP INTO ONE OF SEVERAL FUNDS TO PAY THE COST OF MEDICAL CARE. UNCOMPENSATED CARE WILL BE REDUCED.

ALSO CONSIDER THAT IF AN INDIVIDUAL HAS NO WORRIES ABOUT FINDING ADEQUATE HEALTH CARE COVERAGE, THE INDIVIDUAL HAS THE RIGHT TO SWITCH PROFESSIONS IF HE OR SHE CHOOSES. AN EXAMPLE OF THIS WOULD BE AN INDIVIDUAL CURRENTLY WORKING FOR AN EMPLOYER, BUT WISHING TO START HIS OWN BUSINESS. IN THE PAST, THIS INDIVIDUAL MAY NOT HAVE DONE THIS FOR FEAR OF LOSING HEALTH CARE COVERAGE. THUS, THE POSSIBLE LOSS OF TAX REVENUE TO THE STATE AND LOCAL UNITS OF GOVERNMENT.

ANOTHER EXAMPLE WOULD BE THE POSTPONEMENT OF NEEDED MEDICAL CARE WHEN UNINSURED. SUCH A POSTPONEMENT COULD RESULT IN MORE COSTLY CARE AT A LATER DATE. WITH ADEQUATE COVERAGE, THE MEDICAL CARE COULD BE MORE PREVENTIVE.

I MIGHT ADD THAT WHILE THE COST TO OPERATE A STATE HEALTH POOL WILL CONTINUE TO RISE THROUGHOUT THE FIRST FIVE OR TEN YEARS, THE COST SHOULD EVENTUALLY STABILIZE. THIS IS BASED ON OUR RESEARCH AND ACTUAL OPERATING STATISTICS OF EXISTING POOLS. WHEN ONE TAKES A CLOSE LOOK AT THE TOTAL HEALTH AND ACCIDENT INSURANCE PREMIUMS COLLECTED FROM ALL CARRIERS IN A GIVEN YEAR IN A STATE, YOU WILL FIND THE TOTAL COST TO OPERATE A POOL IS SOMEWHERE AROUND 1 PERCENT OF THIS FIGURE. CA BELIEVES THIS IS A SMALL PRICE TO PAY TO ALLOW EVERY CITIZEN WITH THE RIGHT TO PURCHASE HEALTH INSURANCE COVERAGE.

DURING THE PAST THREE YEARS, COMMUNICATING FOR AGRICULTURE HAS PROVIDED ASSISTANCE TO OVER THIRTY STATES CONSIDERING STATE HEALTH POOL LEGISLATION. SUCH ASSISTANCE HAS INVOLVED MODEL LEGISLATION, TESTIMONY, RESEARCH, OPERATIONAL SUMMARIES OF EXISTING POOLS AND COST AND PARTICIPANT PROJECTIONS FOR NEW STATE POOLS.

WHAT WE HAVE LEARNED FROM OUR INVOLVEMENT IS THAT THE NEED IS TRULY THERE FOR STATE HEALTH POOLS. WE STILL HAVE A LONG WAY TO GO IN ASSURING THAT SUCH POOLS ARE EFFECTIVE AND PROVIDE COVERAGE FOR THOSE INTENDED. WE MUST CONTINUE OUR EFFORTS TO SEE THAT ALL STATE POOLS ARE ADVERTISED TO THE PUBLIC. BUT WE ARE MAKING HEADWAY.

PASSAGE OF S.2403 WILL PROVIDE THE IMPETUS NEEDED TO REMOVE THE ERISA PROBLEM CITED IN SO MANY STATES. WE SUPPORT THE LANGUAGE USED TO DEFINE STATE HEALTH POOLS AS WELL AS THE POTENTIAL TAX TO BE PLACED ON SELF INSURERS NOT WILLING TO VOLUNTARILY JOIN STATE POOLS.

THE REMAINING SECTIONS OF S.2403 IN LOOKING AT OTHER AREAS OF HEALTH CARE ACCESS FOR AMERICANS ARE COMMENDABLE. WHILE CA HAS NO SPECIFIC RECOMMENDATIONS AS TO THE REMAINDER OF H.R. 4742, WE APPLAUD YOUR EFFORTS TO BROADEN THE BASE FOR HEALTH INSURANCE COVERAGE AS WELL AS TO PROVIDE BREAKS FOR SMALL BUSINESS AND SELF-EMPLOYED INDIVIDUALS. CA HAS LONG ENDORSED EFFORTS TO ASSIST THE SELF-EMPLOYED WITH TAX BREAKS FOR HEALTH INSURANCE PREMIUMS AND WILL CONTINUE TO WORK FOR THIS GOAL.

CA'S PHILOSOPHY IS BEST SUMMED UP BY A MEMBER WHOSE WIFE COULD NOT QUALIFY FOR HEALTH INSURANCE. "I DO NOT BELIEVE WE SHOULD HAVE SOCIALIZED MEDICINE, BUT I DO BELIEVE THAT GOVERNMENT SHOULD LEGISLATE SO THAT EVERY PERSON IS ELIGIBLE FOR A PRIVATE INSURANCE PLAN. I AM NOT ASKING FOR FREE INSURANCE FOR MY WIFE, I'M JUST ASKING FOR THE OPPORTUNITY TO CARRY INSURANCE ON HER."

CA HAS OFFERED A GROUP INSURANCE PROGRAM TO OUR MEMBERS SINCE 1977. DESIGNED BY CA, OUR PROGRAM IS KNOWN AS THE CASH DEDUCTIBLE CONCEPT AND HAS BEEN VERY SUCCESSFUL IN ALLOWING OUR MEMBERS TO CONTROL THEIR HEALTH COSTS. WE ARE CONTINUALLY UPDATING OUR PROGRAM TO INCLUDE THE LATEST COST CONTAINMENT FEATURES AVAILABLE ANYWHERE.

CA AND ITS MEMBERS HAVE ALWAYS BELIEVED THAT ONE OF THE REASONS GOVERNMENT WAS CREATED WAS TO ASSIST CITIZENS IN THOSE AREAS IN WHICH THEY CANNOT HELP THEMSELVES. IT IS OUR BELIEF THAT CREATION OF STATE HEALTH INSURANCE POOLS AND PASSAGE OF LEGISLATION SUCH AS S. B. 2403 WILL ASSIST IN ACCOMPLISHING THIS GOAL.

AGAIN, WE APPRECIATE THE OPPORTUNITY TO APPEAR BEFORE THIS COMMITTEE TODAY TO SPEAK ON THE ISSUE OF HIGH RISK HEALTH INSURANCE POOLS AND IN SUPPORT OF THIS LEGISLATION. I APPLAUD YOUR EFFORTS AND SINCERELY HOPE THAT SUCH LEGISLATION IS GIVEN SERIOUS CONSIDERATION.

I HAVE DISTRIBUTED COPIES OF MATERIAL COMPILED BY COMMUNICATING FOR AGRICULTURE WHICH OUTLINE AND COMPARE THE VARIOUS PLANS IN EFFECT THROUGHOUT THE UNITED STATES, THEIR PREMIUMS, COSTS, CLAIMS, ASSESSMENTS AND NUMBER OF PARTICIPANTS; AS WELL AS COMPARISON DATA OF THE MANY STATES CONSIDERING THIS LEGISLATION.

WE OFFER YOU THE EXPERIENCE OF OUR ORGANIZATION IN DEVELOPING AND IMPLEMENTING SUCH LEGISLATION, ITS PROS AND CONS, AND OTHER AREAS WHERE I CAN BE OF ASSISTANCE.

THANK YOU.

Communicating for Agriculture
National Headquarters: (218) 739-3241
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HEALTH INSURANCE RISK-SHARING POOLS THROUGHOUT THE UNITED STATES

The enclosed information pertains to legislation creating a health insurance risk-sharing pool for individuals who find difficulty in purchasing adqequate health insurance coverage due to pre-existing health conditions.

All information has been compiled by Communicating for Agriculture in cooperation with numerous other sources and is accurate to the best of CA's knowledge. Data is extracted from the latest draft legislation from each state.

Material may be reproduced and quoted so long as credit is given as to the cource of the material.

For further information, please contact Communicating for Agriculture at CA Support Services or at the National Headquarters.

January 1, 1986

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STATUS OF LEGISLATION

CREATING COMPREHENSIVE HEALTH INSURANCE POOL

STATE	STATUS
Arizona	Introduced in 1984, failed.
California	Introduced in 1984, and 1985, failed. Reintroduced in 1986.
Colorado	Introduced in 1985, failed. Reintroduced in 1986.
*Connecticut	Program in effect - 1976.
*Florida	Program in effect - October 1983.
Illinois	Introduced in 1985, failed. New draft introduced in 1986.
*Indiana	Program in effect - July 1982.
Iowa	Introduced in 1983 and 1985, failed. New draft introduced in 1986.
Kansas	Introduced in 1985, failed. Should be reintroduced in 1986.
Kentucky	Introduced in 1984, failed.
Maryland	Resolution to study issue in 1985, failed.
*Minnesota	Program in effect - June 1976.
Mississippi	Introduced and failed in 1984 and 1985. Reintroduced in 1986.
Missouri	Introduced in 1984 and 1985, failed. Reintroduced in 1986.
*Montana	Passed and signed into law - 1985.
*Nebraska	Passed and signed into law - 1985.
New York	Introduced in 1985, carried over to 1986.

*North Dakota	Program in effect - 1981.
Ohio	Introduced in 1983-1984 Session, failed.
Oregon	Introduced in 1985, failed. To be reintroduced in 1986.
*Rhode Island	Program in effect.
South Carolina	Introduced in 1985, carried over to 1986.
South Dakota	Passed '84 Legislature, Vetoed by Governor. Reintroduced in 1985, failed.
Tennessee	Introduced in 1986.
Texas	Introduced in 1977, failed.
Virginia	Chose not to introduce, however legislation was passed in 1985 mandating open enrollment for all citizens through Blue Cross/Blue Shield.
*Wisconsin	Program in effect - June 1981.

Additional states are expected to introduce legislation in 1986.

*Plans in effect

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January 1, 1986

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BOARD COMPOSITION

STATE	BOARD
Arizona	5 members
California	13 members - 2 reps from disability insurers, 1 rep from a community care facility, 2 from an intermediate care facility and 8 from the public.
Colorado	9 members - To include at least 1 domestic insurance company, 1 domestic non-profit health care service plan, 1 member of the general public, 1 member from a self insurer, and 1 member from an HMO.
*Connecticut	7 members selected by participating members
*Florida	7 members - 3 appointed by insurance commissioner (1 from general public, 1 from medical providers, 1 from health agents); 4 appointed by members with at least 1 nonprofit insurer and 1 domestic insurer
Illinois	9 members - 2 representatives of not-for-profit insurers, 2 other participating insurers, 3 public members, 1 rep from the IL Health Care Cost Containment Council and the Director of Insurance.
*Indiana	5 to 9 members selected by members of the pool
Iowa	Not less than 5 nor more than 9 members selected by the members of the association.
Kansas	9 members - to include 3 foreign insurance companies, 2 domestic insurance companies, 2 licensed independent insurance agents, 2 members of the general public
Kentucky	To be determined by the members, but must include at least 1 domestic insurance company and 1 domestic nonprofit health care service plan
*Minnesota	7 members selected by members of the pool and 2 members appointed by the Governor.
Mississippi	This legislation apportions the applicants out to each insurance company rather than creating a separate high risk pool.
Missouri	To be determined by the members but must include at least 1 domestic nonprofit health care service plan
Montana	8 members - 1 from each of the top seven insurers in premium volumes and 1 to represent the public interest

*Nebraska	9 members - to include at least 1 domestic insurance company, 1 domestic hospital service corporation, 1 member of a health maintenance organization, and 1 member of the general public.
New York	10 members - To include at least 2 representatives of domestic insurance company, 2 representatives of domestic non-profit health care service plan, 2 members of the general public.
*North Dakota	10 members - 1 from each member of the 10 insurers with the highest annual premium volumes
Ohio	9 members - 7 to be appointed by Supt. of Insurance (2 from participating nonprofit insurance corporation, 2 others from participating insurers, 3 public members at least 2 of whom are members of population covered by the plan and not affiliated with insurance or medical parties) Other 2 shall be representative of the health policy council and the Supt. of Insurance or his designee.
Oregon	9 members - to include 2 members from participating insurers, 2 members from non-profit corp. insurers, 3 public members, 1 from Health Dept. and 1 from Commissioners' office
Rhode Island	No information available
South Carolina	7 members - To include at least 2 domestic insurance companies, including the largest
South Dakota	7 members - 3 to be appointed by Insurance Commissioner and 4 to be appointed by the members with at least 1 nonprofit insurer and 1 domestic insurer
Tennessee	9 members - to include at least 1 representative from a domestic insurance company, 1 rep of a foreign insurance company, 1 rep from a domestic non-profit health care plan, 1 rep from an HMO, 1 rep from a health-related profession, 1 from the general public, and 1 to represent an uninsurable group.
Texas	To be determined by the State Board of Insurance
*Wisconsin	9 members - Insurance Commissioner or his Rep., Rep. of Health Policy Council Reps. of 2 nonprofit insurers appointed by Commissioner, Reps. of 2 other insurers appointed by Commissioner, 3 public members appointed by the Commissioner.

*Plans in effect
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MAXIMUM BENEFITS PROVIDED

*Many states offer more than one plan. Unless otherwise noted the limit shown applies to all plans.

STATE	AMOUNT
Arizona	$1,000,000 Lifetime Benefit
California	$1,000,000 Lifetime Benefit
Colorado	$500,000 Lifetime Benefit
*Connecticut	$1,000,000 Lifetime Benefit
*Florida	$500,000 Lifetime Benefit
Illinois	$500,000 Lifetime Benefit
*Indiana	Plan I - No limit specified Plan II - $50,000 Lifetime Benefit
Iowa	$250,000 Lifetime Benefit
Kansas	No limit in legislation
Kentucky	$1,000,000 Lifetime Benefit
*Minnesota	$250,000 Lifetime Benefit-Regular Plan $100,000 Lifetime Benefit-Medicare Supplement
Mississippi	To be determined.
Missouri	$1,000,000 Lifetime Benefit
Montana	Not less than $100,000 lifetime benefit
*Nebraska	$500,000 Lifetime Benefit
New York	$500,000 Lifetime Benefit
*North Dakota	$250,000 Lifetime Benefit
Ohio	$250,000 Lifetime Benefit
Oregon	$250,000 Lifetime Benefit
*Rhode Island	No information available

South Carolina	$1,000,000 Lifetime Benefit
Tennessee	$500,000 Lifetime Benefit
South Dakota	$50,000 Annual - $250,000 Lifetime
Texas	No limit in legislation
*Wisconsin	$250,000 Lifetime Benefit

*Plans in effect

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DEDUCTIBLES

*Many states offer more than one plan. The amounts listed are all deductibles available.

STATE	AMOUNT
Arizona	$200
California	$1,000
Colorado	$250, $500, $1,000 and any other amount determined by the Board
*Connecticut	$400 $1,000 $1,500
*Florida	$1,000 $1,500 $2,000
Illinois	$250 $500/individual $500/$1,000 family
*Indiana	$200 $500 $1,000
Iowa	$500 $1,000 and any other amount determined by the Board.
Kansas	To be determined by Board
Kentucky	To be determined by Board
*Minnesota	$500 $1,000
Mississippi	To be determined.
Missouri	To be determined by Board
*Montana	Not to exceed $1,000
*Nebraska	To be determined by Board
New York	$500 $1,000, and any other amount determined by the Board
*North Dakota	$150 $500 $1,000
Ohio	$1,000
Oregon	$1,000
*Rhode Island	·Personal resource payment required

South Carolina	To be determined by Board
South Dakota	$500 $1,000 and any other amount determined by the Board
Tennessee	$500 $2,000 and any other amount determined by the Board.
Texas	$200
*Wisconsin	Plan I - $1,000 Plan II - Medicare Part A Deductible

*Plans in effect

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STOP LOSS

*Many states offer more than one plan. Unless otherwise noted the limit shown applies to all plans.

STATE	AMOUNT
Arizona	$1,000/individual, $2,000/family
California	$3,000/individual, $5,000/family
Colorado	$1,500/individual, $3,000/family
*Connecticut	$2,000/individual, $4,000/family
*Florida	Regular - Plan I $2,500/individual, $4,000/family Plan II $3,000/individual, $4,500/family Plan III $3,500/individual, $5,000/family Medicare Plan I $1,500/individual, $4,000/family Plan II $2,000/individual, $4,500/family Plan III $2,500/individual, $5,000/family
Illinois	$1,500/individual, $3,000/family, $500/Medicare
*Indiana	$1,000/individual, $2,000/family
Kansas	To be determined by Board
Kentucky	To be determined by Board
Iowa	$1,500 or $2,000/individual, $3,000 or $4,000/family
*Minnesota	Regular Plans - $3,000/individual Medicare Supplement - $1,000/individual
Mississippi	To be determined.
Missouri	To be determined by board
*Montana	$5,000/individual
*Nebraska	To be determined by board
New York	$1,500/individual, $3,000/family
*North Dakota	$3,000/individual

Ohio	$500/medicine eligible, $1,500/individual, $3,000/family
Oregon	$1,500/individual, $3,000/family, $500/Medicare
*Rhode Island	No information available
South Carolina	To be determined by Board
South Dakota	$3,000/individual
Tennessee	$500 deductible: $1,500/individual, $2,500/family $2,000 deductible: $2,500/individual, $3,500/family
Texas	$200 or 10% of insured's adjusted gross income, Whichever is greater
*Wisconsin	Plan I - $2,000/individual, $4,000/family Plan II - $500

*Plans in effect

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PREMIUM CAPS

STATE	RATE
Arizona	150% maximum
California	To be determined.
Colorado	150% initial, 200% maximum
*Connecticut	125% minimum, 150% maximum
*Florida	150% initial, 200% maximum
Illinois	125% maximum
*Indiana	150% maximum
Iowa	150% maximum
Kansas	To be be determined by Board
Kentucky	150% initial, 200% maximum
*Minnesota	125% maximum
Mississippi	To be determined.
Missouri	150% initial, 200% maximum
Montana	150% initial, 400% maximum
*Nebraska	135% initial, 160% maximum
New York	150% maximum
*North Dakota	135% maximum
Ohio	130% maximum for first three years
Oregon	130% maximum for first three years
*Rhode Island	Premium resource payment required
South Carolina	150% initial, no maximum
South Dakota	125% initial, 200% maximum
Tennessee	150% maximum
Texas	To be determined by Board
*Wisconsin	150% maximum

*Plans in effect

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WAITING PERIOD

(For Pre-existing Conditions)

STATE	LENGTH
Arizona	6 month wait if condition manifested or treated within previous 6 months
California	To be determined.
Colorado	6 month wait if condition manifested or treated within previous 6 months
*Connecticut	12 month wait if condition manifested or treated within previous 6 months
*Florida	12 month wait if condition manifested or treated within previous 6 months
Illinois	6 month wait if condition manifested or treated within previous 6 months
*Indiana	6 month wait if condition manifested or treated within previous 6 months
Kansas	To be determined by Board
Iowa	6 month wait if condition manifested or treated within previous 6 months
Kentucky	12 month wait if condition manifested or treated within previous 6 months
*Minnesota	6 month wait if condition manifested or treated within previous 90 days
Mississippi	To be determined.
Missouri	12 month wait if condition manifested or treated within previous 6 months
Montana	12 month wait if condition manifested or treated within previous 5 years
*Nebraska	6 month wait if condition manifested or treated within previous 6 months
New York	6 month wait if condition manifested or treated within previous 6 months

*North Dakota	6 month wait if condition manifested or treated within previous 90 days
Ohio	30 day wait if condition manifested or treated within previous 6 months
Oregon	30 day wait if condition manifested or treated within previous 6 months
*Rhode Island	No information available
South Carolina	6 month wait if condition manifested or treated within previous 6 months
South Dakota	12 month wait if condition manifested or treated within previous 6 months
Tennessee	6 month wait if condition manifested or treated within previous 6 months
Texas	6 month wait if condition manifested or treated within previous 6 months
*Wisconsin	6 month wait if condition manifested or treated within previous 6 months

*Plans in effect

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ELIGIBILITY CRITERIA

STATE	REQUIREMENT
Arizona	-Must be resident -Not eligible if similar coverage at equal rate or less -Not eligible if entitled to Medicaid or Medicare
California	-Must be resident
Colorado	-Must be resident -Must have been rejected by one carrier -Not eligible if similar coverage at equal rate or less -Not eligible if entitled to Medicare
*Connecticut	-Must be resident -Not eligible if entitled to Medicare -All other requirements are waived
*Florida	-Must be resident -Must be rejected by two carriers -Not eligible if entitled to Medicare, however Medicare supplement plan available
Illinois	-Must be resident for 30 days -Must be rejected by one carrier -Not eligible if entitled to Medicare -Not eligible if similar coverage at equal rate or less -Eligible if current coverage has a restrictive clause -Have clause which waives certain requirements
*Indiana	-Must be resident -Must be rejected by two carriers -Not eligible if entitled to Medicare -For 10% additional premium, pre-existing condition waiting period is waived -Have list of conditions which waive rejection by two carriers
Iowa	-Must be resident -Must be rejected by one carrier -Not eligible if similar coverage at equal rate or less
Kansas	-To be determined by Board

Kentucky	-Must be resident -Not eligible if entitled to Medicare -Must be rejected by one carrier
*Minnesota	-Must be resident -Must be rejected by one carrier
Mississippi	-To be determined
Missouri	-Must be resident -Not eligible if entitled to Medicare or Medicaid -Must be rejected by one carrier
Montana	-Must be resident -Must have been rejected by two carriers
*Nebraska	-Must be resident for 6 months -Not eligible if entitled to Medicare or Medicaid -Must be rejected by one carrier
New York	-Must be resident -Not eligible if entitled to Medicare or Medicaid -Must be rejected by one carrier
*North Dakota	-Must be resident for six months -Must be rejected by one carrier
Ohio	-Must be resident for 30 days -Must be rejected by two carriers -Not eligible if entitled to Medicare or Medicaid
Oregon	-Must be resident for 30 days -Must have been rejected by two carriers -Must have notice of reduction or limitation of coverage or increase in premium of 50% or more
*Rhode Island	No information available
South Carolina	-Must be resident for 6 months -Not eligible if entitled to Medicare or Medicaid -Must be rejected by one carrier -Not eligible if similar coverage at equal rate or less
South Dakota	-Must be resident -Must be rejected by two carriers
Tennessee	-Must be resident -Must be rejected by one carrier -Medicare plan to be offered

Texas	-Must be resident -Must be rejected by one carrier
*Wisconsin	-Must be resident -Must be rejected by two carriers

NOTE: Many states also have requirements relating to whether or not an individual has a policy with a rider or whether such coverage is rated.

*Plans in effect

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POOL FUNDING

STATE	SOURCE
Arizona	Assessment with credit applied against premium tax and income tax. Use formula of approximately 20% per year
California	The state has created a start-up fund of $750,000
Colorado	Assessment with credit applied against premium tax and income tax
*Connecticut	Assessment of losses to participating insurers
*Florida	Assessment with credit applied against premium tax and income tax. Maximum assessment of 1% per year on premiums or greater than premium tax. Use formula of approximately 20% per year for offset
Illinois	Assessment with credit applied against premium tax and income tax. Also allowed to increase rates to offset assessment.
*Indiana	Assessment with credit applied against premium tax and income tax. Also allowed to increase rates to offset assessment.
Iowa	Fund created and if assessment is needed these assessments shall be credited against premium taxes paid.
Kansas	To be determined by Board
Kentucky	Assessment of losses to participating insurers
*Minnesota	Assessment with credit applied against premium tax and income tax
Mississippi	To be determined.
Missouri	Assessment of losses to participating insurers
Montana	Assessment with credit applied against premium tax
*Nebraska	Assessment with credit applied against premium tax
New York	Assessment to insurers, although state has not yet determined if tax credit will be allowed

*North Dakota	Assessment of losses to participating insurers
Ohio	Assessment of losses to participating insurers
Oregon	Assessment of losses to participating insurers
*Rhode Island	No information available
South Carolina	Assessment with credit applied against premium tax and income tax
South Dakota	Assessment with credit applied against premium tax. Use formula of approximately 20% per year for writeoff
Tennessee	Assessment of losses to participating insurers with credit applied against premium tax.
Texas	Assessment of losses to participating insurers
*Wisconsin	Assessment of losses to participating insurers plus special fund created by state to subsidize premiums for low-income policyholders.

*Plans in effect

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FEES ALLOWED

*States listed below have fees set by statute. All others are to be determined by the board.

California	Agent Referral Fee - $100
*Connecticut	Agent Referral Fee - $20
*Florida	Agent Referral Fee - $75
*Indiana	Agent Referral Fee - $25
Iowa	Agent Referral Fee - $25
*Minnesota	Agent Referral Fee - $50 Administrator - 12 1/2% maximum
*Montana	Agent Referral Fee - $25 Administrator - 12% maximum
*North Dakota	Agent Referral Fee - $25 Administrator - 12 1/2% maximum
*Rhode Island	No information available
*Wisconsin	Agent Referral Fee - $35

*Plans in effect

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January 1, 1986

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CONNECTICUT JANUARY 1986

I. PLAN SUMMARY

1. Connecticut Contact:	Ms. Sandra Downes The Travelers Insurance Co. One Tower Square Hartford, Connecticut 06115 (203) 527-5369
2. Plan Administrator:	The Travelers Insurance Co.
3. Effective Date:	1976
4. Board Composition:	7 members selected by participating members.
5. Benefit:	$1,000,000 Lifetime Benefit
6. Deductible:	$400 $1,000 $1,500
7. Stop Loss:	$2,000/Individual $4,000/Family
8. Premium Cap:	125% Minimum 150% Maximum
9. Waiting Period:	12 months for pre-existing conditions
10. Pre-existing conditions:	Not covered if diagnosed or treated within 6 months preceding the policy date until 12 months after the policy date.
11. Eligibility Criteria:	Must be resident. Not eligible if eligible for medicare
12. Agent fee:	$20
13. Medicare qualified plan:	No

CONNECTICUT

II. OPERATIONAL DATA

The Health Reinsurance Association Connecticut (HRA(C)) varies somewhat from many of the other State plans. While the plan spells out the benefits, coverages, etc., the State of Connecticut has no requirement that an individual must have been rejected prior to applying for the pool.

Because the only eligibility requirement is being a state resident ineligible for Medicare, the plan has many good risks (those between jobs, students just graduated and not yet employed, group conversions, etc.)

Until 9/1/84, Connecticut actually had two separate pools. One was operated by Blue Cross/Blue Shield, the other by the HRA(C). Because BC/BS operated their own plan with benefits identical to the HRA(C)'s, they were not required to pay assessments on the pool operated by the HRA(C).

BLUE CROSS/BLUE SHIELD STATISTICS:

1. Total individuals covered by plan at end of 1983: 27,122

$200 deductible -	Males	7,577	TOTAL	17,963
	Females	6,707		
	Children	3,679		
$500 deductible -	Males	1,875	TOTAL	5,504
	Females	2,305		
	Children	1,324		
$750 deductible -	Males	1,171	TOTAL	3,655
	Females	1,547		
	Children	937		

Blue Cross/Blue Shield became mutualized as of 9/1/84 and now refers uninsurables to the HRA(C). However, existing BC/BS policyholders are allowed to continue coverage under their BC/BS policy.

HEALTH REINSURANCE ASSOCIATION STATISTICS:

HRA(C) excluding Blue Cross/Blue Shield.

1. Total individuals covered by plan at end of 1983: 4,399

$200 deductible -	Males	1,159		
	Females	955	TOTAL	2,327
	Children	213		
$500 deductible -	Males	277		
	Females	328	TOTAL	695
	Children	90		
$750 deductible -	Males	538		
	Females	629	TOTAL	1,377
	Children	210		

2. Total individuals covered by plan at end of 1984: 3,579

$200 deductible -	Males	582		
	Females	376	TOTAL	1,046
	Children	88		
$500 deductible -	Males	388		
	Females	420	TOTAL	905
	Children	97		
$750 deductible -	Males	647		
	Females	757	TOTAL	1,628
	Children	224		

In January of 1985, deductibles on the HRA(C) plans were doubled to $400, $1,000, and $1,500. It should also be noted that the reduction in total individuals on the small deductible plan is probably because of larger premium increases on this plan, than on the higher deductible plans during the past few years.

ASSESSMENTS

Assessment to participating insurers for 1983: Approx. $ 500,000.
Assessment to participating insurers for 1984: Approx. $1,000,000.
No premium tax credit is allowed for this assessment.

It should also be noted that BC/BS will now be assessed, but only for the pool of policies issued after 9/1/84.

The HRA(C) will maintain separate pools: the old pool for policyholders of record as of 9/1/84, and a new pool for policies issued after 9/1/84. The HRA(C) will continue separate accounting for the two pools until the number of policies in the old pool is reduced to 500 or until Sept. 1988, whichever occurs first. At such time, the old and the new pools will be merged. Assessments for the old group up to the time of the merger will be made to participating insurers excluding Blue Cross/Blue shield.

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FLORIDA

JANUARY 1986

I. PLAN SUMMARY

1. Florida Contact: W. R. Pace, SCHA Coordinator
G-15C Larson Building
Tallahassee, Florida 32301
(904) 487-2161

2. Plan Administrator: Gulf Life Insurance Company

3. Effective Date: October 1983

4. Board Composition: 7 members - 3 appointed by the Insurance Commissioner (1 from general public, 1 from medical providers, 1 from health agents); 4 appointed by members with at least 1 nonprofit insurer and 1 domestic insurer

5. Benefit: $500,000 Lifetime Benefit

6. Deductible: $1,000 $1,500 $2,000

7. Stop Loss: Regular - Plan I $2,500/individual, $4,000/family
Plan II $3,000/individual, $4,500/family
Plan III $3,500/individual, $5,000/family

Medicare Plan I $1,500/individual, $4,000/family
Plan II $2,000/individual, $4,500/family
Plan III $2,500/individual, $5,000/family

8. Premium Cap: 150% Initial, 200% Maximum

9. Waiting Period: 12 months for pre-existing conditions

10. Pre-existing conditions: Not covered if diagnosed or treated within 6 months preceding the policy date until 12 months after the policy date.

11. Eligibility Criteria: Rejected by two carriers for similar coverage and benefits

12. Agent fee: $75.00 one-time referral fee

13. Medicare qualified plan: Yes

FLORIDA
II. OPERATIONAL DATA

1. Total individuals covered by plan at end of:

1981	N/A
1982	N/A
1983	49
1984	382
As of January 1, 1986	664

2. Total premiums collected by plan at end of:

1981	$ N/A
1982	$ N/A
1983	$ 23,758.68
1984	$ 505,798.20
1985	$ N/A

3. Total claims paid by plan at end of:

1981	$ N/A
1982	$ N/A
1983	$ None
1984	$ 141,429.88
As of January 1, 1986	$ 938,922.92

4. Total assessment to members of plan for:

1981	$ N/A
1982	$ N/A
1983	$ None
1984	$ None

5. What was the cost to administer the plan in:

1981	$ N/A
1982	$ N/A
1983	$ included in 1984 figure
1984	$ 69,113.72

6. Does your state allow for a premium tax credit on the assessment? X Yes ___ No

Comments

7. Is there a maximum percentage assessment allowed towards the companies (such as 1%)? X Yes ___ No

Comments: Not to exceed 1% of health insurance premiums written.

8. What was the percentage assessed to members (such as .8%) at the end of:

1981	N/A
1982	N/A
1983	None
1984	None

9. What were the total accident & health premiums written by all companies in your state at the end of:

1981	$ N/A
1982	$ N/A
1983	$2,907,493,643.00
1984	$3,255,182,304.00

10. What were the total premium taxes paid by all companies in your state at the end of:

1981	$ N/A
1982	$ N/A
1983	$ 106,490,947.22
1984	$ 122,646,379.26

11. Did the above taxes paid include all companies or were some exempt from paying taxes (such as self-insurers)?
Some were exempt (most domestic insurers are exempt)

12. What problems has your plan experienced?
No major problems after 1 1/2 years of operation.

13. Additional comments:

We believe the plan is being well publicized and is increasing at a normal growth rate.

Participants:

$1,000 Deductible	277
$1,500 Deductible	77
$2,000 Deductible	270

No assessment is anticipated in Florida for 1986. There have been 863 claims processed since inception of the pool. Total claims are $859,485.36

The only increase in premiums is in the Medicare Eligible rates in accordance with increases in Medicare deductibles.

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INDIANA

JANUARY 1986

I. PLAN SUMMARY

1. Indiana Contact: Mr. Leonard P. Weinstein
   Deputy Commissioner
   Indiana Dept. of Insurance
   509 State Office Bldg.
   Indianapolis, IN 46204
   (317) 232-2418
2. Plan Administrator: Mutual of Omaha
3. Effective Date: July 1982
4. Board Composition: 5 to 9 members selected by members of the pool
5. Benefit:
   Plan I - No limit
   Plan II - No limit, $50,000 Lifetime Benefit for mental and nervous disorders
6. Deductible:
   Plan I - $200
   Plan II - $200, $500, $1,000
7. Stop Loss:
   Plan I - $1,000/Individual; $2,000 Family
   Plan II - $1,000/Individual; $2,000/Family
   $1,500/Individual; $3,000/Family
   $2,000/Individual; $4,000/Family
8. Premium Cap: 150% Maximum
9. Waiting Period: 6 months for pre-existing conditions
10. Eligibility Criteria: Rejected by two carriers, notified of benefit reduction, premium increase or not eligible for medicare. Criteria may be waived under certain conditions.
11. Pre-existing conditions: Not covered if diagnosed or treated within 6 months preceding the policy date until 6 months after the policy date. May be waived under certain conditions.
12. Agent fee: $25.00
13. Medicare qualified plan: No

INDIANA
II. OPERATIONAL DATA

1. Total individuals covered by plan at end of:

1981	-0-
1982	41
1983	2,288
1984	3,510
As of December 1, 1985	3,305

2. Total premiums collected by plan at end of:

1981	$ -0-
1982	$ 34,479.69
1983	$ 2,352,179.23
1984	$ 6,356,995.39

3. Total claims paid by plan at end of:

1981	$ -0-
1982	$ -0-
1983	$ 217,877.60
1984	$ 6,843,690.79

4. Total assessment to members of plan for:

1981	$ -0-
1982	$ 53,300.00
1983	$ 10,601.00
1984	$ 134,077.00
1985	$ 3,340,079.00

5. What was the total cost to administer the plan in:

1981	$ -0-
1982	$ 28,936.61
1983	$ 56,511.83
1984	$ 256,462.35

6. Does your state allow for a premium tax credit on the assessment? X Yes ___ No

Comments ______

7. Is there a maximum percentage assessment allowed towards the companies (such as 1%)? ___ Yes X No

Comments: ______

8. What was the percentage assessed to members (such as .8%) at the end of:

1981	
1982	
1983	
1984	

Does not use %

9. What were the total premiums collected by all companies in your state at the end of:

1981 $
1982 $
1983 $
1984 $

10. What were the total premium taxes paid by all companies in your state at the end of:

1981 $
1982 $
1983 $
1984 $

11. Did the above taxes paid include all companies or were some exempt from paying taxes (such as self-insurers)?

12. What problems has your plan experienced?

13. Additional comments:

The Indiana plan has a provision whereby the pre-existing condition waiting period can be waived if the individual is willing to pay an additional premium of 10% over the life of the contract. This provision has worked very well. As of November 1, 1984, over 1,400 policy-holders were using this waiver.

Indiana also has a list of conditions whereby a rejection notice from an insurance carrier is not required to become eligible for the plan.

Plan participants:

$200 Deductible	1,108
$500 Deductible	582
$1,000 Deductible	1,615

The Indiana pool is averaging 1,600 claim audits per month.

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MINNESOTA **JANUARY 1986**

I. PLAN SUMMARY

1. Minnesota Contact:	Mr. Dave Platt Manager, Contracts and Compliance Department Blue Cross-Blue Shield P.O. Box 64560 St. Paul, MN 55164 (612) 456-8561
2. Plan Administrator:	Blue Cross-Blue Shield
3. Effective Date:	June 1976
4. Board Composition:	7 members selected by members of the pool and 2 members appointed by the Governor
5. Benefit:	Regular Plan - $250,000 Lifetime Benefit Medicare Supplement - $100,000 Lifetime Benefit
6. Deductible:	$500, $1,000
7. Stop Loss:	Regular plans - $3,000/Individual Medicare Supplement - $1,000/Individual
8. Premium Cap:	125% Maximum
9. Waiting Period:	6 Months for pre-existing conditions
10. Pre-existing conditions:	Not covered if diagnosed or treated within 90 days preceding the policy date until 6 months after the policy date.
11. Eligibility Criteria:	Rejected by one carrier Rider by one carrier
12. Agent fee:	Referral fee of $50
13. Medicare qualified plan:	Yes

MINNESOTA
II. OPERATIONAL DATA

1. Total individuals covered by plan at end of:

1981 2,918
1982 4,250
1983 6,669
1984 9,158
As of December 1, 1985 11,179

2. Total premiums collected by plan at end of:

1981 $ 1,305,245.00
1982 $ 2,325,060.00
1983 $ 4,082,351.00
1984 $ 6,413,829.00

3. Total claims paid by plan at end of:

1981 $ 2,852,845.00
1982 $ 4,514,172.00
1983 $ 6,981,967.00
1984 $ 9,761,835.00

4. Total assessment to members of plan for:

1981 $ 1,000,000.00
1982 $ 3,000,818.00
1983 $ 3,487,532.00
1984 $ 4,795,071.00
(Interim Assessment) - 1985 $ 2,500,000.00

5. What was the total cost to administer the plan in:

1981 $ 163,156.00
1982 $ 298,823.00
1983 $ 383,741.00
1984 $ 665,100.00

6. Does your state allow for a premium tax credit on the assessment? _X_ Yes ___ No

Comments ______________________________

7. Is there a maximum percentage assessment allowed towards the companies (such as 1%)? ___ Yes _X_ No

Comments ______________________________

8. What was the percentage assessed to members (such as .8%) at the end of:

1981 -
1982 -
1983 -
1984 -

Each assessment is based on the ratio of the contributing members total amount of accident and health insurance premium received from or on behalf of Minnesota residents divided by the total cost of accident and health insurance premium received by all Association Contributing Members from or on behalf of Minnesota residents, as determined by the Commissioner of Commerce for the state of Minnesota.

9. What were the total premiums collected by all companies in your state at the end of:

1981	$ N/A
1982	$ N/A
1983	$ N/A
1984	$ N/A

10. What were the total premium taxes paid by all companies in your state at the end of:

1981	$ N/A
1982	$ N/A
1983	$ N/A
1984	$ N/A

11. Did the above taxes paid include all companies or were some exempt from paying taxes (such as self-insurers)?

Self-Insurers and non-profit service plan corporations do not pay premium tax.

12. What problems has your plan experienced?

13. Additional comments:

Individuals covered -

Plan 1	($1,000 deductible)	3,668
Plan 2	($500 deductible)	6,544
Plan 4	(Med Supplement - 65 & over)	744
Plan 5	(Med Supplement - Under 65)	223
		11,179

In 1984, the Minnesota pool processed 37,350 claims. The average claim was $261.36

Minnesota feels that adjustments made to the plan since its inception have made for a very good program.

Minnesota also has a listing of eighteen conditions which allow for automatic acceptance into the pool without having to receive a rejection notice from an insurance carrier.

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MONTANA **JANUARY 1986**

I. PLAN SUMMARY

1. Montana Contact:	Mr. Elmer V. "Sonny" Omholt Commissioner of Insurance Mitchell Building P.O. Box 4009 Helena, Montana 59601 (406) 444-2996
2. Plan Administrator:	Not yet awarded
3. Effective Date:	Legislation signed into law April 1985
4. Board Composition:	8 members - 1 from each of the top seven insurers in premium volume and 1 to represent the public interest
5. Benefit:	Not less than $100,000 Lifetime Benefit
6. Deductible:	Not to exceed $1,000
7. Stop Loss:	$5,000 Individual
8. Premium Cap:	150% Initial, 400% Maximum
9. Waiting Period:	12 months for pre-existing conditions
10. Pre-existing conditions:	Not covered if diagnosed or treated within 5 years preceding the policy date. May be waived under certain conditions.
11. Eligibility criteria:	Must be resident, must have been rejected by two carriers
12. Agent fee:	$25.00
13. Medicare qualified plan:	No

Very little data available, as plan is not yet operational.

MONTANA
II. OPERATIONAL DATA

1. Total individuals covered by plan at end of:

1985 ______________

2. Total premiums collected by plan at end of:

1985 $______________

3. Total claims paid by plan at end of:

1985 $______________

4. Total assessment to members of plan for:

1985 $______________

5. What was the cost to administer the plan in:

1985 $______________

6. Does your state allow for a premium tax credit on the assessment?

_X_ Yes ___ No

Comments: ______________________________

7. Is there a maximum percentage assessment allowed towards the companies (such as 1%)? ___ Yes ___ No

Comments: ______________________________

8. What was the percentage assessed to members (such as .8%) at the end of:

1985 ______________

9. What were the total health insurance premiums collected by all companies in your state at the end of:

1983 $ N/A
1984 $ N/A

10. What were the total premium taxes paid by all companies in your state at the end of:

1983 $ N/A
1984 $ N/A

11. Did the above taxes paid include all companies or were some exempt from paying taxes (such as self-insurers)?

12. What problems has your plan experienced?

13. Additional comments:

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NEBRASKA JANUARY 1986

I. PLAN SUMMARY

1. Nebraska Contact:	Mr. Dan Quine Department of Insurance State Capitol Building P.O. Box 94699 Lincoln, Nebraska 68509 (402)471-2201
2. Plan Administrator:	Not yet awarded
3. Effective Date:	Legislation signed into law April 1985
4. Board Composition:	9 members - 1 Rep. of a domestic insurance co., 1 Rep. of a domestic hospital service corp. plan, 1 Rep. of a health maintenance organization, and 1 Rep. of general public
5. Benefit:	$500,000 Lifetime Benefit
6. Deductible:	To be determined by Board
7. Stop Loss:	To be determined by Board
8. Premium Cap:	135% Initial, 165% Maximum
9. Waiting Period:	6 months for pre-existing conditions
10. Pre-existing conditions:	Not covered if diagnosed or treated within 6 months preceding the policy date. Pre-existing condition clause may also be waived upon payment of additional premiums.
11. Eligibility criteria:	Resident for 6 months, Rejected by 1 carrier, Ridered for over 12 months, insurance at rate exceeding pool rate
12. Agent fee:	To be determined by Board
13. Medicare qualified plan:	No

Very little data available, as plan is not yet operational.

NEBRASKA
II. OPERATIONAL DATA

1. Total individuals covered by plan at end of:

1985 0

2. Total premiums collected by plan at end of:

1985 $ 0

3. Total claims paid by plan at end of:

1985 $ 0

4. Total assessment to members of plan for:

1985 $ 0

5. What was the cost to administer the plan in:

1985 $ 0

6. Does your state allow for a premium tax credit on the assessment?

X Yes ___ No

Comments: Insurers are allowed 100% credit offset against premium taxes paid to the state.

7. Is there a maximum percentage assessment allowed towards the companies (such as 1%)? ___ Yes X No

Comments:

8. What was the percentage assessed to members (such as .8%) at the end of:

1985 N/A

9. What were the total health insurance premiums collected by all companies in your state at the end of:

1983 $ 559,617,899.
1984 $ 612,212,499.

10. What were the total premium taxes paid by all companies in your state at the end of:

1983 $ 26,060,055.
1984 $ 28,398,815.

11. Did the above taxes paid include all companies or were some exempt from paying taxes (such as self-insurers)?

Domestic companies pay .06% premium tax and foreign companies pay 2% premium taxes.

12. What problems has your plan experienced?

13. Additional comments:

Insurers are required to include a notice of the existence of the pool in any rejection of an application for health insurance coverage for reasons of health.

As of December 15, 1985, the pool was not yet operational. Company representatives to the Board have been selected. The Director of Insurance will select the individual to serve as a representative of the general public when the final Board member is selected, the board has 180 days to develop the plan of operation.

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NORTH DAKOTA **JANUARY 1986**

I. PLAN SUMMARY

1. North Dakota Contact:	Mr. Bob Carlson 4510 - 13th Ave. SW Fargo, ND 58121-0001 (701) 282-1235
2. Plan Administrator:	Blue Cross-Blue Shield
3. Effective Date:	June 1981
4. Board Composition:	10 members - 1 from each member of the 10 insurers with the highest annual premium volumes
5. Benefit:	$250,000 Lifetime Benefit
6. Deductible:	$150 $500 $1,000
7. Stop Loss:	$3,000/Individual
8. Premium Cap:	135% Maximum
9. Waiting Period:	6 Months for pre-existing conditions
10. Pre-existing conditions:	Not covered if diagnosed or treated within 90 days preceding the policy date until 6 months after the policy date. Waiting period is waived if applicant has been covered under an insured health plan within past year. Pre-existing condition clause may also be waived upon payment of additional premium.
11. Eligibility Criteria:	Rejected by one carrier Riders by two carriers Resident for six months
12. Agent fee:	Referral fee of $25
13. Medicare qualified plan:	Yes

NORTH DAKOTA
II. OPERATIONAL DATA

1. Total individuals covered by plan at end of:

1981	-0-
1982	78
1983	245
1984	615
As of December 1, 1985	983

2. Total premiums collected by plan at end of:

1981	$ -0-
1982	$ 73,408.00
1983	$ 138,666.00
1984	$ 455,874.00

3. Total claims paid by plan at end of:

1981	$ -0-
1982	$ 103,400.00
1983	$ 345,918.00
1984	$ 1,058,694.00

4. Total assessment to members of plan for:

1981	$ -0-
1982	$ 49,862.00
1983	$ 229,483.00
1984	$ 605,367.00
1985	$ 600,000.00 (approx)

5. What was the cost to administer the program in:

1981	$ -0-
1982	$ 33,111.00
1983	$ 25,306.00
1984	$ 35,904.00

6. Does your state allow for a premium tax credit on the assessment? X Yes ___ No

Comments

7. Is there a maximum percentage assessment allowed towards the companies (such as 1%)? ___ Yes X No

Comments

8. What was the percentage assessed to members (such as .8%) at the end of:

1981	-0-
1982	.03%
1983	.11%
1984	N/A

9. What were the total premiums collected by all companies in your state at the end of:

1981 $ N/A
1982 $ N/A
1983 $73,667,853.00
1984 $ N/A

10. What were the total premium taxes paid by all companies in your state at the end of:

1981 $ N/A
1982 $ N/A
1983 $ N/A
1984 $ N/A

11. Did the above taxes paid include all companies or were some exempt from paying taxes (such as self-insurers)?

Self-Insurers do not report to the State Insurance Department, and are therefore exempt.

12. What problems has your plan experienced?
No major problems.

13. Additional comments:

North Dakota participation

$ 150 Deductible plan	547
$ 500 Deductible plan	164
$1,000 Deductibel plan	102
Medicare Supplement Plan	170
TOTAL	983

Enrollment seems to be picking up. Approximately 30 individuals are signed up per month.

Assessments - Assessments are made to all companies doing more than $100,000 of accident and health insurance business in the state. Assessments are based on each company's premium volume as compared to the total for all companies. Assessments are a direct offset against premium taxes.

Lead carrier expenses are, by law, limited to 12.5% of premium.

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JANUARY 1986

RHODE ISLAND PLAN SUMMARY

The state of Rhode Island has a plan which differs markedly from that of the other state risk-sharing plans. It is intended to protect its State residents against "extraordinary costs of catastrophic illness or injury by supplementing their insurance program".

Rhode Island recipients must requalify each year for coverage and must insure a specified amount of out-of-pocket medical expenses in order to be eligible for coverage. These expenses, called "personal resource payments", are determined in relation to the extent of coverage, if any, that an eligible person is otherwise entitled. The payment will be smallest for families with fully qualified health insurance policies and largest for those with an unqualified policy or no coverage at all. The other State plans, rather than supplementing insurance, focus only on those individuals who are unable to purchase any health insurance.

SPECIFIC REQUIREMENTS UNDER RHODE ISLAND PLAN

1) A rejection from an insurance company is not required to apply for the Rhode Island Plan.

2) A medicare recipient is eligible to apply for the plan.

3) There are no pre-existing clauses in the plan.

4) There is no maximum lifetime limit under the plan.

5) No specific premiums are set, as personal resource payments are required.

6) Very few people are covered under the Rhode Island plan at any one time.

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WISCONSIN **JANUARY 1986**

I. PLAN SUMMARY

1. Wisconsin Contact:	Ms. Rosemary Van Susteren P.O. Box 7873 Madison, WI 53707 (608) 267-2305
2. Plan Administrator:	Mutual of Omaha
3. Effective Date:	June 1981
4. Board Composition:	9 members - Commissioner or his Rep., Rep. of Health Policy Council, Reps. of 2 nonprofit insurers appointed by Comm., Reps. of 2 other insurers, 3 public members appt. by Commissioner
5. Benefit:	$250,000 Lifetime Benefit
6. Deductible:	Plan I - $1,000 Plan II - Medicare Part A deductible
7. Stop Loss:	Plan I - $2,000/Individual $4,000/Family Plan II - $500
8. Premium Cap:	150% Maximum
9. Waiting Period:	6 months for pre-existing conditions
10. Pre-existing conditions:	Not covered if diagnosed or treated within 6 months preceding the policy date until 6 months after the policy date.
11. Eligibility Criteria:	Cancelled or rejected by two carriers, rider by one carrier 50% or greater premium increase by one carrier.
12. Agent fee:	Referral fee of $35
13. Medicare qualified plan:	Yes, for persons under 65

WISCONSIN
II. OPERATIONAL DATA

1. Total individuals covered by plan at end of:

1981	309
1982	977
1983	1,798
1984	1,918
As of December 1, 1985	1,928

2. Total premiums collected by plan at end of:

1981	$ 127,740.00
1982	$ 618,216.00
1983	$ 1,232,352.00
1984	$ 2,079,996.00
As of October 1, 1985	$ 1,900,000.00 (approx)

3. Total claims paid by plan at end of:

1981	$ 37,165.00
1982	$ 1,144,686.00
1983	$ 2,463,703.00
1984	$ 3,104,604.00
As of October 1, 1985	$ 2,400,000.00 (approx)

4. Total assessment to members of plan for:

1981	$ 100,000.00
1982	$ 1,300,000.00
1983	$ 2,000,000.00
1984	$ 1,700,000.00
As of December 1, 1985	$ None to date

5. What was the cost to administer the plan in:

1981	$ 28,212.00
1982	$ 85,206.00
1983	$ 156,964.00
1984	$ 196,338.00

6. Does your state allow for a premium tax credit on the assessment? ___ Yes X No

Comments

7. Is there a maximum percentage assessment allowed towards the companies (such as 1%)? ___ Yes X No

Comments:

8. What was the percentage assessed to members (such as .8%) at the end of:

1981	N/A
1982	N/A
1983	N/A
1984	N/A

9. What were the total premiums collected by all companies in your state at the end of:

1981 $ N/A
1982 $ N/A
1983 $ N/A
1984 $ N/A

10. What were the total premium taxes paid by all companies in your state at the end of:

1981 $ N/A
1982 $ N/A
1983 $ N/A
1984 $ N/A

11. Did the above taxes paid include all companies or were some exempt from paying taxes (such as self-insurers)?
N/A

12. What problems has your plan experienced? Coordinating benefits with other government programs. Cash flow problems experienced first two years.

13. Additional comments:

The 1985 Wisconsin Legislature passed legislation creating a fund to assist low-income policyholders in paying premiums. This fund was approximately $425,000 for 1985, however was reduced in September by approximately $40,000. As an example of the program, during the month of September, 1985, 443 insureds were processed for the subsidy program, ranging from 6% to 30% of a reduction in premiums.

On the entire plan, Wisconsin has 1,928 participants as of December 1, 1985. The breakdown is 1,695 on the $1,000 deductible plan and 233 on the Medicare plan.

The rates for 1986 show no increase over the 1985 rates for the $1,000 deductible plan. The Medicare plan experienced a 10% increase.

For the first nine months of 1985, premiums collected were $1,900,000 and claims paid were $2,400,000. Premiums were roughly 25% of claims.

Prepared Statement of John F. Troy

Good Morning, Mr. Chairman, and Members of the Subcommittee. I am John Troy, Vice President of the Employee Benefits Division of the Travelers Insurance Company.

I appear before the Subcommittee today on behalf of the Health Insurance Association of America. The HIAA is a national trade association comprised of 335 companies which underwrite or administer approximately 85% of the private commercial health coverage in this country. I am accompanied by James A. Dorsch, Washington Counsel for the HIAA.

We appreciate this opportunity to comment on proposals to make health insurance available for persons considered uninsurable due to poor health. We particularly commend you, Chairman Durenberger, and Senators Heinz, Kennedy and Riegle for your sponsorship of Federal legislation on this issue, S. 2403 and S. 1372. With your leadership, we can make private health coverage available to those Americans who might otherwise be denied insurance because of poor health.

The HIAA fully supports legislation to encourage states to establish voluntary risk pools for uninsurables. The commercial health insurance industry has actively supported such a measure since the late 1960's as a key building block in efforts to bridge existing gaps in coverage. Now is the time to make this concept a reality.

Joining the HIAA in its support of state risk pools for uninsurables are more than 3 dozen national organizations representing millions of this country's most vulnerable citizens--the sick, handicapped, and elderly. Together we recognize that in many cases those unable to obtain health coverage are working people who are willing and able to pay for insurance but are unable to obtain it because of poor health. In other cases, they are older people who, upon leaving their employment, find they cannot purchase individual coverage. At the time they need health insurance most, they are left without it. The inability to obtain adequate insurance has serious consequences not only for these individuals but for their families as well.

Before continuing, I should point out that the concern here is focused on a relatively small fraction of the population, and that the vast majority of working Americans are already covered by health insurance. The HIAA estimates that at the end of 1983, approximately 176 million persons under age 65, including spouses and children, were covered by one or more forms of private health protection. Eighty-five percent are covered by employee group insurance, usually without individual medical underwriting. About fifteen percent are covered by individual health insurance policies. These individual policies will generally continue coverage for persons with health problems once purchased, but in accordance with general insurance principles must have been purchased while the buyer was in good health. Thus, some individuals, such as those not eligible for group or group conversion coverage and those never having been in good health, may fall between the cracks.

The fact that the great majority of Americans do have some type of insurance coverage, however, provides little comfort to those who must go without. The HIAA feels that universal private health coverage for all employees and their dependents is an important national social goal; in this vein, we see no reason not to cover everyone who's willing to pay. Thus state high risk pools are designed to be the insurer of last resort for individuals who want health insurance protection and currently can't get it in today's health insurance market place.

State high risk pools work by spreading the excess financial risk of covering otherwise uninsurable individuals among all health insurance plans in the state, including self-insured businesses. The risk pools set a ceiling on the premium charged which, when combined with the health status of the persons in the pool, can generally be expected to produce pool losses. The key to effective operation of the pools is to assure that these losses are spread proportionately among all the competitors in the health insurance market place. They do not represent a great financial burden on any one insurer if financed by adequate premiums and if the losses are spread equitably over the entire insured population.

For example, in 1985 the losses of the Minnesota state pool were approximately $5 million. If spread over all insured lives under age 65 in Minnesota, including all protected employees and their dependents, losses would be approximately $1.40 per person per year. In Connecticut, 1985 losses were approximately $1.5 million or $.50 per person.

Eleven states currently have some form of health insurance pool for uninsurables: Connecticut, Florida, Indiana, Iowa, Minnesota, Montana, Nebraska, North Dakota, Rhode Island, Tennessee, and Wisconsin. In 1975, the HIAA supported the creation of the first state risk pool in Connecticut. Because of the this pool, there are now no uninsurables in Connecticut. Under the Connecticut law, the losses of the pool were to be shared among all the competitors in the health insurance market place -- the commercial insurers, Blue Cross/Blue Shield, HMO's, and self-insured employers -- on a pro-rata basis. Thus, the high-risk individuals received coverage but the competitive market place was not upset.

Subsequent court interpretation of the 1974 Employees Retirement Income Security Act (ERISA), however, which precludes the states from regulating employee benefit plans, means self-insured employers need not share in any pool losses. As more and more large employers self-insure, the burden of pool losses falls harder and harder on an ever decreasing ba[illegible] principally small employers and individual purchasers of health insurance policies, who are already paying higher costs for their health protection.

The state risk pool provisions of S. 2403 and S. 1372 provide a powerful incentive for all states to establish risk pools by levying a 10 percent excise tax on employers, including self-insured employers, that do not participate in qualified pools. Because employers will find it much less costly to participate in the pool, there will be no revenues from the tax. Instead, the actual financing of the pools will come from the private sector. The design and operation of the insurance pools will be at the discretion of each state, and they will be regulated by the state like any other insurance product. The HIAA endorses all of these concepts.

We should stress that the state risk pool proposal would not require a single dollar in Federal revenue. Mr. Chairman, when you consider this in light of the fact that industry and consumers are joined in support of a measure to solve the health care needs of Americans currently left out of our private health insurance system, we see little reason why the measure should not be swiftly approved by Congress.

The HIAA believes that this legislation is a creative solution to a growing problem. While it does not resolve the health care problems of the poor, it will prevent many Americans from being forced into poverty and onto Medicaid by catastrophic medical bills.

It will help ameliorate hospitals' growing bad debt and uncompensated care problems, thus making more funds available for the truly needy.

Mr. Chairman, with your permission, I would like to comment very briefly on the other major sections of the Access to Health Care Act. Our industry certainly endorses the concept of providing tax incentives to individuals and small business people to purchase health insurance for themselves and their employees. However, the concept of requiring employers to continue payment for health insurance coverage for terminated employees for a period of 4 months requires thoughtful consideration. Health insurance in

America is provided primarily through employment based coverage. Consequently, any requirement to continue coverage for a temporary period certainly has merit. We are, however, concerned about the possible counter-cyclical impact of the requirement to make employers responsible for payment. Frequently, this requirement would come into effect at a time when an employer, and particularly a smaller employer, may be least able to afford the extra burden of covering terminated employees. It is quite possible, that with some additional changes in the tax law, pre-funding of these kinds of benefits may be feasible. However, we would like to reserve judgment and suggest continued study of this aspect of the proposal to carefully consider all of the economic implications.

As you know, we are currently implementing the Federal Continuation of Benefits provisions of the Comprehensive Omnibus Budget Reconciliation Act of 1986. The superimposition of Federal requirements on existing state legislation is causing an immense amount of confusion, not only for our insured employers, but for the Federal drafters of regulations as well. It will be important in this piece of legislation and other Federal legislation that impose insurance requirements on employers, to consider carefully the interaction of Federal laws with state laws and to override state laws, if necessary. We have discussed this issue with you in the past, and are prepared to renew this discussion with you and your staff.

Finally, we are firmly convinced that as the American health care system moves to a more competitive approach, the issue of uncompensated care must be dealt with decisively. States pools that redistribute hospital revenues to needy institutions have been established in 5 states and seem to be working. I would point out, however, that I am aware of at least 15 responsible national trade associations and consulting firms that are examining broad-based solutions to the problems of funding uncompensated care.

I believe there is universal agreement that the solution must be a broad-based partnership between government and the private sector, and I am sure that given just a little more time and study, the right answers will emerge. We would prefer more definitive instructions to the states, rather than the somewhat open-ended approach described in this legislation.

In conclusion, we believe the risk-pool provision contained in the Access to Health Care Act will ensure the availability of health insurance for all Americans, regardless of the condition of their health, with an absolute minimum of Federal regulation, and at no cost to the Federal treasury. The Health Insurance Association of America stands ready to assist you, Mr. Chairman, in securing enactment in Congress of this important health care measure.

A copy of the statement of the Coalition for Health Insurance Availability is attached for the record. Thank You.

Coalition for Health Insurance Availability

Statement in Support of the Health Insurance Risk Pooling Provisions of the Improved Access to Health Care Inititive

June 9, 1986

The Coalition for Health Insurance Availability, comprised of 41 national organizations representing individuals with chronic health conditions or disabilities and older Americans, supports the provision of the "Access to Health Care Act" that will provide access to health insurance to individuals and families who are willing but unable to purchase it. This legislation (H.R. 4742 and S. 2402/S. 2403) was introduced on May 1 by Congressmen Stark and Gradison in the House of Representatives and by Senators Kennedy, Durenberger, Heinz and Riegle in the United States Senate.

Many of those unable to obtain insurance coverage are people with developmental disabilities, physical or mental impairments, and chronic health conditions. In many cases these are working people who are willing and able to pay for health insurance but are unable to purchase it because each has a pre-existing condition. In other cases they are older people who, upon leaving their employment, find they cannot purchase individual coverage. At the time they need health insurance most, they are left without it. The inability to obtain adequate insurance has serious consequences not only for these individuals but for their families as well.

The Stark-Kennedy bills would encourage states to establish risk pools to make reasonably priced insurance available to those who cannot purchase it on the open market.

Several models for an effective risk pool already exist. Nine states already have some form of risk pool offering comprehensive major medical insurance to people considered by insurers as "high risks." These states are Connecticut, Florida, Indiana, Minnesota, Montana, Nebraska, North Dakota, Rhode Island, and Wisconsin. Purchasers pay into the pool like any other group health coverage. If the pool experiences losses, those losses are proportionately shared by all the insurers conducting business in the state.

The Stark-Kennedy bill will not require the expenditure of any federal funds. This legislation simply establishes minimum standards based on the experiences of successful state pools. Each pool would be established and regulated in each state similar to other state insurance programs.

Millions of people who, because of health problems, are unable to purchase health insurance in any other fashion, would be afforded coverage. That is why we support the enactment of risk pooling legislation. The Health Insurance Association of America representing the commercial health insurance companies also supports the risk pooling provision contained in the Stark-Kennedy bills.

The denial of health insurance frequently means the denial of health care. It is critical that risk pooling legislation be enacted this year.

COALITION FOR HEALTH INSURANCE AVAILABILITY

ACLD, Inc. An Association for Children and Adults with Learning Disabilities
Alliance for the Neurologically Impaired
American Association of Retired Persons
American College of Gastroenterology
American Diabetes Association
American Foundation for the Blind
American Liver Foundation
American Medical Student Association
American Speech-Language-Hearing Association
Amyotrophic Lateral Sclerosis Association
Arthritis Foundation
Association for Retarded Citizens
Cooley's Anemia Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation of America
Handicapped Organized Women, Inc.
Health Insurance Association of America
Huntington's Disease Foundation of America
Immune Deficiency Foundation
Lupus Foundation of America
MPS (Mucopolysaccharidoses) Research Funding Center, Inc.
National Association of Children's Hospitals and Related Institutions, Inc.
National Association of Developmental Disabilities Councils
National Coalition for Rare Disorders
National Consumers League
National Easter Seal Society
National Head Injury Foundation
National Foundation for Ileitis and Colitis
National Huntington's Disease Association
National Mental Health Association
National Multiple Sclerosis Society
National Rehabilitation Association
National Society for Children and Adults with Autism
National Sudden Infant Death Syndrome Foundation
National Women's Health Network
Sickle Cell Support Association
Sick People Need Insurance (SPINS)
Sick Kids Need Involved People (SKIP)
Spina Bifida Association of America
Tourette Syndrome Association, Inc.
United Cerebral Palsy Associations, Inc.

For Further Information:

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American Diabetes Association Epilepsy Foundation of America

Prepared Statement of Andrew P. Czajkowski

Mr. Chairman and Members of the Committee, I am Andrew P. Czajkowski, President of Blue Cross and Blue Shield of Minnesota. On behalf of the Blue Cross and Blue Shield Association, the national coordinating organization for the nation's Blue Cross and Blue Shield Plans, I am pleased to take this opportunity to present my perspective on the issues raised by S. 2403, the "Access to Health Care Act of 1986."

I am particularly pleased to be here today because of my prior involvement in the Minnesota risk pool, the Minnesota Comprehensive Health Association. As you know, Minnesota was the first state to adopt the risk pool concept. I was the founder of that pool and President from 1976 to 1983.

Increasing the availability of health insurance protection, whether on a group or individual basis, for as broad a population as possible and finding effective means to ensure access to hospital care for all citizens are laudable goals and ones which the Blue Cross and Blue Shield Association and its member Plans would join with the sponsors of S. 2403 in seeking to achieve. However, we are concerned that such broad and sweeping federal action as is proposed in this legislation may not be the most appropriate means of reaching these shared goals.

S. 2403 would: 1) provide for the establishment of state insurance pools for the high risk population; 2) require states to establish programs to ensure access to hospital care for the uninsured and the underinsured; 3) require employers to pay for extended health coverage for laid-off workers; and 4) take steps to improve access to health insurance for small employers.

State Risk Pools

Section 2, which is the first substantive provision of the bill, would create "incentives" for the establishment of state risk pools for the medically uninsurable. We would emphasize most particularly our concern that this section would, in essence, mandate rather than encourage state action.

Our concerns about a mandate relate to three areas in which we believe this legislation could have a detrimental effect on both state governments and the private health insurance system. First, a mandate, by its very nature, is prescriptive. By forcing states to establish these rather narrowly-defined risk pools, S. 2403 would limit the ability of states to address their particular problem in a way best designed to suit their situation. In addition, the mandate set forth in the bill would affect states with pools already in operation, as well as those without pools, by imposing a single federal standard for coverage drafted without reference to the needs of the individual states. Finally, such a mandate would undermine the existence of private insurance coverage where it is available. While the Blue Cross and Blue Shield Association does not oppose state risk pools for the uninsurable, we would strongly urge Congress not to make them mandatory.

State risk pools have been established in ten states. Enrollment has been significantly lower and losses have been significantly higher than expected. At present, only about 20,000 people are covered through state risk pools. However, these pools do represent one option for dealing with the lack of availability of individual health insurance for a limited group of persons: those with existing health problems who have sufficient resources to afford to purchase relatively expensive insurance. Nevertheless, the need for such pools is not universal.

We believe that there are a variety of options from which a state may wish to select to deal with the needs of its uninsurable population. S. 2403's absolute mandate of risk pools as the only solution to the problem is unnecessarily prescriptive and would stifle the ability of state governments to develop systems which deal more appropriately with their special needs. For example, states may elect to set minimum levels of free care to be provided by hospitals or create revenue pools to directly subsidize care for the uninsurable regardless of economic status. Others might prefer to provide incentives for insurers to enroll higher risk individuals or establish special programs for this population through their network of public health facilities.

We would also point out that the subsidy for pool coverage, if a state elects to establish one, will be high. Existing pools must assess their members amounts sometimes exceeding $800 annually per person enrolled in the pool. This cost, which under S. 2403 must be borne by the private sector, either paid by an insurer or by an employer, will be a significant factor for small businesses in their decision to maintain health benefit programs for their employees. Indeed, it may be a factor in their decision to continue to do business in a particular state. The assessed cost of a state risk pool under S. 2403 applies only to businesses with health benefit plans and approximates a tax on these businesses, penalizing them for having benefits. Businesses without employee health benefits will not have to pay any of the costs of the pool. In light of this, a state may want to subsidize its pool in a manner other than the one prescribed in the bill.

Even those states which have already chosen to establish risk pools would be affected by the provisions of S. 2403. None of the existing state pools would meet the standards for coverage which would be established by this legislation. Thus, states with pools already in operation would be forced to make legislative and benefit changes in order to meet these requirements which could result in unnecessary confusion for those currently enrolled in pools.

The imposition of both a federal coverage standard for state risk pools and a mandated method of financing that coverage would take away the flexibility necessary to respond to the unique needs of the people of the individual states.

In many states, individual health insurance is available through the private market to those who do not have employer-provided health benefits, regardless of their medical condition. Where that is the case, a mandated pool would, in effect, lead to the elimination of that more affordable private coverage and replace it with the more expensive coverage made available through a high risk only pool.

Many Blue Cross and Blue Shield Plans offer coverage to any applicant for individual coverage regardless of their medical condition. The cost of this coverage is community-rated, which means that the premiums are not based on an individual's medical condition but on the experience of the entire nongroup population insured by the Plan. Because of the large pool of individual enrollees -- a typical Blue Cross and Blue Shield Plan will have about 15 percent nongroup enrollment -- the costs attributable to the sicker, high-risk enrollees are averaged out over a large number of people that includes those who are healthy and are not using medical services. This makes the coverage much more affordable than even a heavily subsidized risk pool that, by definition, includes only high cost, high risk enrollees.

For example, an individual may obtain coverage from Blue Cross and Blue Shield of Vermont at any time throughout the year, regardless of how ill he or she already is. This nongroup coverage pays in full the cost of 120 days of a hospital stay, and physician services are paid on a fee-schedule basis. The only deductibles imposed are the costs of the first two office visits made each year and $10 for the first diagnostic x-ray and diagnostic laboratory tests performed each year. The premium charged for the sickest person enrolling is the same as for the healthiest. We would emphasize that coverage is not excludeed for pre-existing medical conditions (other than during a 9 month waiting period) and the premium is the same regardless of the medical condition of the enrollee.

Furthermore, Blue Cross and Blue Shield Plans are constantly reassessing their ability to offer nongroup coverage without regard to the medical condition of the applicant. For example, Blue Cross and Blue Shield of North Carolina just introduced an open enrollment product specifically for state residents who are considered uninsurable because of their health status. All North Carolina residents under age 65 are eligible for coverage without answering health questions, undergoing a physical examination, paying a special enrollment fee, or joining a group. The program offers a comprehensive major medical plan with a $500 deductible, and members are not subjected to riders or denials based on medical conditions. The program is community rated, so the premium charged for this coverage is considerably lower than what would be charged by a pooling association.

A federally mandated risk pool in any of the states where Blue Cross and Blue Shield Plans now offer nongroup coverage without any underwriting restrictions to all applicants would very likely mean that the Plan could no longer continue to offer coverage on such a basis. High risk individuals would be sent to the pool to obtain coverage. In such cases, that community would lose what a majority of the experts agree is the best solution -- a large pool of both healthy and sick individuals participating in a community-rated, privately-sponsored program.

It is the recommendation of the Blue Cross and Blue Shield Association that Section 2 of S. 2403 be amended to eliminate its current mandatory approach to state pools. We believe a gradual approach would be more effective. An essential first step would be to eliminate a major obstacle which states have had to deal with in establishing risk pools.

Currently, ERISA's Section 514 prohibits states from applying their insurance laws to employee welfare benefit plans. This ERISA preemption of state regulation of employee benefit plans prevents states from including self-funded plans in pools. The existing risk pool statutes are part of their respective state insurance codes and so can only apply to insurers doing business in the state. We believe that this inability to reach self-funded benefit plans and thereby achieve more broad-based financing has been a primary consideration in a number of states which have not established pools.

S. 2403 could address the ERISA problem by providing for a federal penalty applicable to all employers who do not participate in any type of risk pool established voluntarily by a state -- where the state determines that they should participate. This would clearly signal the Congress' support for state risk pools as a means of providing coverage for the uninsurable population. We believe that it is unnecessary, at this time, to go beyond this point and actually mandate the establishment of these pools in all states. After a reasonable period of time, the federal government could follow up this legislation with a comprehensive study evaluating the availability of individual health insurance, both in the private market and through state pools, and, at that time, re-examine the need for further action.

Uncompensated Care

Blue Cross and Blue Shield Association is very much aware of the growing public concern surrounding the effect of uncompensated care on the nation's hospitals. Based on our lengthy experience in hospital payment, we have participated in a variety of activities, both public and private, which have focused on developing and evaluating solutions to this potentially serious problem. As a result, while we recognize that the cost of uncompensated care is becoming a significant financial burden for certain hospitals, we have observed that it does not appear to be of such critical proportion to justify the sweeping action embodied in Section 3 of S. 2403, dealing with coverage for the "uninsured" and the "underinsured."

Section 3 would require that all states almost immediately take one of two options to deal with uncompensated care.

- Establish a state program to provide health care coverage to both the uninsured and the underinsured, or
- Establish a financing mechanism for the unreimbursed costs incurred by every hospital in the state for "medically necessary...services."

The components of "uncompensated care" differ significantly on a state-by-state basis and the same solution is simply not appropriate for all of them. We believe that such a mandate, accompanied by the penalty of witholding federal matching funds for Medicaid administrative expenses, is more drastic than required at this time. S. 2403 fails to recognize either the differences in population or the very real financial constraints on some state budgets.

We believe that it is also important to note that, just as the states are different, so are their hospitals. Many hospitals are currently enjoying high profit margins and to require states to "cover their losses" through some new government program may not be the most appropriate allocation of often limited state resources. An increase in taxes, be they business taxes or "bed" taxes, to finance such a program as proposed in this legislation could hurt the perception of a state's business climate and disturb prospective economic development which would be of benefit to all its citizens. State governments are already acting to deal with the problem of uncompensated care and we believe that they should be free to do so in light of the the needs of their own population.

Extension of Coverage

With regard to the first provision of Section 4 of S.2403, which would require employers to continue payment of their portion of the cost of health benefits for laid-off workers, we would second the concerns which have already been expressed by the business community. The cost of this requirement could force some employers to discontinue their benefit plans altogether, thus having exactly the opposite effect of that intended by the sponsors.

We are also concerned that this expansion of the continuation of coverage provision included in the 1986 Consolidated Omnibus Budget Reconciliation Act would compound confusion resulting from the initial legislative action. Numerous problems have not yet begun to be resolved. We would strongly urge you to delay even considering action to expand this mandate at least until regulations for the existing requirement have been promulgated.

The second provision of Section 4 would require employers to allow spouses of employees, who have coverage under another benefit plan and lose that coverage, to have the opportunity to enroll in the benefit plan without evidence of insurability. This is an option which some Blue Cross and Blue Shield Plans voluntarily implemented during during the early 1980s when unemployment rates were at their highest. While we question the advisability of federal intervention in private benefit plans, we believe that this sort of coordination between benefit plans represents a step toward the goal of maximizing the availability of health care coverage.

Small Business

Our final comments will focus on Sections 5 and 6 and their goal of increasing access to health insurance for small employers and self-employed individuals. Section 5 would allow self-employed individuals to take a business deduction for the cost of their own health benefits when they also provide health benefits to their employees. Section 6 would instruct the Secretary of HHS to arrange for studies and demonstration projects aimed at reducing costs of health insurance for small employers and self-employed individuals.

We support the proposed tax deduction for the cost of benefits for self-employed persons as a means to make coverage more affordable. However, we are concerned about the possible impact of the proposed demonstration projects.

Blue Cross and Blue Shield Plans are very involved with providing health benefits to small groups. We appreciate the interest of Congress in the needs of these businesses for adequate and affordable insurance which is reflected in S. 2403. However, we would express serious reservations about the apparent direct involvement of the federal government in the business of insurance which the proposed demonstration projects contemplate. The regulation of insurance is, as specifically provided in the McCarren-Ferguson Act, under the authority of state government and we believe the states have performed their responsibilities well.

For the federal government to intervene in the operation of the private insurance market result in serious problems for both government and insurers. No matter how admirable the goal, demonstration projects which could involve the federal government in contracting for the offering of insurance products through non-insurers should not be undertaken lightly. To encourage entities which may not have a clear understanding of the principles of underwriting or reserving, upon which the financial solvency of insurers depends, could lead to a serious disruption of the health insurance system.

The Blue Cross and Blue Shield Association would strongly encourage that the proposed studies of the small group insurance market be conducted and, in fact, be expanded to include employers of up to 100 employees. Once the market has been carefully reviewed and evaluated, the need for appropriate federal action can be re-examined.

Conclusion

To summarize, the Blue Cross and Blue Shield Association supports the goals of S. 2403 -- to increase the availability of health insurance protection for as broad a population as possible, and to find effective means to ensure access to hospital care for all citizens. We are concerned, however, that the broad federal action proposed in this legislation may not be the most appropriate means of reaching these goals. We would suggest, rather, a more incremental approach to addressing the problem. In particular, we support addressing the problem of states not being able to include self-funded employers in any financing mechanism for voluntary state risk pools.

Prepared Statement of Richard E. Curtis

Mr. Chairman and members of the Committee, I am Richard E. Curtis, Director of Health Policy Studies at the Center for Policy Research the National Governors Association. As you know, over the past two years states have been actively developing policies and programs to help address the needs of the growing number of individuals who do not have adequate financial access to medical services. It should be noted, however, that in areas with the largest concentrations of uninsured poor persons, resource limitations significantly constrain the ability of state and local governments to meet these needs. Further, anomalies in federal law restrict states' latitude to extend private plan coverage for other uninsured populations. It is therefore important that Congress carefully consider potential federal roles to help address this problem.

Although the intent of the Access to Health Care Initiative bill is commendable, several of the specific mechanisms proposed would be problematic for states. The Governors have not adopted a policy position specifically relevant to this bill, but do have a clear perspective regarding the broader issues of appropriate federal and state roles raised by this bill. Mr. Chairman, because of the important intergovernmental issues raised by the bill we greatly appreciate your decision to solicit input on this bill in your role as Chairman of this subcommittee.

As a result of cost containment strategies adopted by the federal Medicare program and other purchasers, health care providers have become increasingly cost competitive and thus less willing to provide free care to uninsured persons. Due to these health care marketplace changes and constraints on private and public sector health insurance coverage, a growing number of

Americans do not have adequate financial access to needed medical care. As the publications we are providing to your subcommittee document, a majority of states have adopted policies to improve access for the uninsured poor persons, often including focused Medicaid expansions. Although these state initiatives are significant, it is important to keep them in perspective. The states that have adopted significant Medicaid expansions tended to have relatively limited programs. This is to be expected because states with the lowest percentage of poor persons covered by Medicaid are likely to experience the greatest problems as health care providers are forced to cut back on their provision of free care. It is also important to note that a number of these states are now facing revenue downturns that will make it extraordinarily difficult to further improve, or in some cases to retain, health care coverage for the poor.

Demographic factors and economic constraints, combined with legal limits on state expenditure growth and requirements for a balanced budget, often severely constrain the ability of individual states to meet the growing need for health care financing programs for the poor. States with disportionately large indigent populations, such as Mississippi, tend to have very limited revenue bases to meet the needs of the poor. South Carolina, for example, has the second highest infant mortality rate and the third lowest per capita income of any state. Further, individual state economic conditions will often severely limit the capacity for expenditure increases even if the national economy prospers. The economic bases of individual states are increasingly vulnerable to factors completely beyond the control of state and even national policy. For example, states with energy- and agricultural-based economies have experienced sharp revenue downturns due to vagaries in international markets. In all, seventeen states had to impose significant cuts during FY 1986 (e.g., Arkansas 6%, Texas 13%, North Dakota 4%, Iowa 3.9%, Mississippi 4.7%) from their originally enacted 1986 budgets. Whether or not federal budget stringencies continue, individual state fiscal circumstances such as these will continue to occur. These economic realities make a substantial federal role in financing health care for the poor essential.

For this reason, the Governors have consistently held that the federal government should be principally responsible for health care financing and other programs to meet the basic needs of the poor. The Governors also strongly oppose federal mandates for state taxes or spending, especially where no federal taxing or spending is committed. Section 3 of the Access to Health Care Initiative bill would mandate states to either establish a subsidy for charity care or provide health insurance for all residents. This provision is clearly inconsistent with Governors' views of appropriate federal and state roles. It is particularly troublesome because there is not even a proportionate federal contribution to the subsidy, and because federal Medicaid funding, the only significant federal role in financing care for the poor, would be terminated if a state did not comply.

States would also have difficulty with the provision requiring that states as employers, but not the federal government, continue to pay health insurance premiums for laid-off workers and their dependents for up to four months. The costs of this proposal would require new expenditures by those states in the weakest fiscal condition. As I mentioned earlier, a growing number of states, particularly farming and energy states, are experiencing revenue declines due to economic circumstances beyond their control. These states have adopted a broad range of budget reductions while attempting to avert state employee layoffs. Some of these states will almost certainly be forced to lay off employees, and they will have no budgetary "fat" left to absorb new costs. In short, mandated new costs for these states could necessitate further layoffs.

Although economic factors limit the capacity of individual states to meet the needs of some populations, they are not as relevant to improving coverage of populations not in need of public subsidies (such as individuals who are self-employed, or who work for small businesses that do not provide employer-supported coverage). Although public sector expenditures are not necessarily needed for these populations, government can pursue strategies that facilitate making health insurance products available and affordable. Profound differences exist across states in the mix and nature of the employment infrastructure and in the demographic characteristics of these populations. Thus, states may often be in a better position than the federal government to target effective solutions. Wisconsin's comprehensive planning efforts to cover the uninsured population will include, for example, a survey of small employers to determine why they do not offer health insurance, and to collect information on their employees such as family incomes. Such information will be useful in developing effective solutions. Possible innovations under consideration include targeting high risk employees of small businesses for participation in the state's insurance pool for medically uninsurable individuals which would reduce the insurance costs for remaining employees and thus make health benefits more affordable for the employer.

Although states do have the potential to develop innovative, targeted solutions, certain federal policies constrain their development. For example, even though ten states have nevertheless adopted insurance pools for high risk individuals, federal law precludes states from requiring participation of self-insured entities in such pools. In many states, self-insured and self-funded entities constitute one-half of the private health benefit market. This federal preemption can therefore be a significant impediment to state health insurance policy innovations.

Section 2 of S. 2402 and S. 2403 would overcome this constraint for a limited population by requiring states for a limited population to establish insurance pools accessable to high risk individuals and requiring all entities offering employment-based health coverage to participate in offsetting any losses. While federal action to facilitate inclusion of self-insured entities in insurance pools would assist state policy efforts, this proposed mandate is restrictive. Several states have chosen to have a separate pool for high risk individuals, but the bill in effect requires pooling high risk people with some group of standard risks. In its high-risk only pool, Wisconsin provides limited premium subsidies based on income with general propose tax revenues. The state is carefully developing other strategies to extend affordable coverage to other populations. While the ability to include self-funded entities in pools would be very helpful to Wisconsin and other states, they should not be required to comply with a single model like that mandated in Section 2. Although there have been a large number of state initiatives to address the needs of the uninsured, there is only limited experience with any one model. Because of this limited experience and the substantially different socioeconomic and health delivery context in each state, uniform mandates of this nature should be avoided.

Federal tax policy constitutes another important health care financing role that is not subject to state purview. The $43 billion federal tax expenditure for employment based health benefits far exceeds federal outlays for Medicaid. Unfortunately, as you have noted Mr. Chairman, this subsidy is not available to a large number of uninsured persons who are in great need of such assistance. Although the Governors do not have a policy position on the tax provisions in S. 2402/S. 2403 and other bills you have introduced, such changes in federal tax policy clearly have great potential to broaden the population with health insurance coverage.

It should also be emphasized that improvements in federal Medicaid law are needed to extend coverage to high priority services and populations. We greatly appreciate your leadership in co-sponsoring legislation to give Governors the latitude to increase the Medicaid eligibility threshold for pregnant women and young children. This will allow states to extend the provision of cost-effective prenatal care to low-income pregnant women and should therefore help reduce uncompensated hospital care costs that disproportionately arise from neonatal intensive care services.

Mr. Chairman, we greatly appreciate your ongoing interest in the state perspective and your commitment to improving health care coverage for those most in need. We look forward to working with you and your staff to refine workable and affordable strategies toward that end.

Prepared Statement of Marilyn Goldwater

MR. CHAIRMAN, AND MEMBERS OF THE SUBCOMMITTEE ON INTERGOVERNMENTAL RELATIONS, I AM DELEGATE MARILYN GOLDWATER, FROM THE STATE OF MARYLAND APPEARING ON BEHALF OF THE NATIONAL CONFERENCE OF STATE LEGISLATURES (NCSL) TO SHARE OUR THOUGHTS WITH YOU ON THE "ACCESS TO HEALTH CARE ACT OF 1986."

THE NATIONAL CONFERENCE OF STATE LEGISLATURES IS THE OFFICIAL REPRESENTATIVE OF THE NATION'S 7,461 STATE LAWMAKERS AND THEIR STAFFS AND IS THE ONLY NATIONAL LEGISLATIVE ORGANIZATION GOVERNED AND FUNDED DIRECTLY BY THE STATES. NCSL PROVIDES BASIC ISSUE RESEARCH, TECHNICAL ASSISTANCE, COMPREHENSIVE FEDERAL BUDGET AND FUNDING DATA AND TRAINING SERVICES TO STATE LEGISLATORS AND STATE LEGISLATIVE STAFF. I AM A MEMBER AND PAST CHAIRWOMAN OF THE NCSL HEALTH AND HUMAN RESOURCES COMMITTEE, THE COMMITTEE RESPONSIBLE FOR GUIDING NCSL POLICY IN THE AREAS OF HEALTH, INCOME SECURITY AND SOCIAL SERVICES. I ALSO HAD THE PLEASURE OF SERVING ON THE NCSL SPECIAL COMMITTEE ON HEALTH CARE COST CONTAINMENT.I AM MAJORITY WHIP IN THE MARYLAND GENERAL ASSEMBLY AND SIT ON THE HOUSE ENVIRONMENTAL MATTERS COMMITTEE, THE JOINT HEALTH OVERSIGHT COMMITTEE, AND THE JOINT COMMITTEE ON FEDERAL-STATE RELATIONS. FINALLY, I HAVE RECENTLY BEEN ELECTED TO SERVE ANOTHER TERM ON THE BOARD OF THE AMERICAN NURSES ASSOCIATION.

PROVIDING HEALTH CARE SERVICES TO THE MEDICALLY INDIGENT, THE UNDERINSURED, THE UNEMPLOYED AND THEIR DEPENDENTS, AND TO ECONOMICALLY AND EFFICIENTLY ASSIST HOSPITALS WITH THE PROBLEM OF UNCOMPENSATED HEALTH CARE, IS A COMPLEX AND DIFFICULT DILEMMA THAT STATE AND LOCAL GOVERNMENTS AND HOSPITALS ARE FACED WITH DAILY. AN ESTIMATED 35 MILLION AMERICANS WERE WITHOUT PRIVATE OR GOVERNMENT-SPONSORED HEALTH INSURANCE IN 1984, A 20 PERCENT INCREASE SINCE 1979.

RECENT STATE SUCCESSES IN CONTAINING HEALTH CARE COSTS HAS HEIGHTENED PUBLIC

AWARENESS OF THE PLIGHT OF THE MEDICALLY INDIGENT AND OF HOSPITALS IN DEALING WITH UNCOMPENSATED CARE. STATE COST CONTAINMENT EFFORTS AND IMPLEMENTATION OF THE FEDERAL PROSPECTIVE PAYMENT PROGRAM FOR MEDICARE HAVE LIMITED THE ABILITY OF HEALTH CARE PROVIDERS FROM SHIFTING COSTS TO PAYING PATIENTS AND TO THIRD PARTY PAYORS. IN ADDITION, EMPLOYERS ARE BY CHOICE AND BY CIRCUMSTANCE BECOMING MORE PRUDENT HEALTH CARE CONSUMERS, PLACING MORE STRESS ON THE SYSTEM.

I WOULD LIKE TO DIGRESS A MOMENT HERE TO PROVIDE SOME GENERAL CHARACTERISTICS OF THE MEDICALLY INDIGENT AND THE TYPES OF SERVICES THEY MOST OFTEN REQUIRE. THE MEDICALLY INDIGENT TEND TO BE YOUNG AND EMPLOYED. ACCORDING TO 1977 DATA COLLECTED IN THE NATIONAL MEDICAL CARE EXPENDITURE SURVEY, A THIRD OF THE MEDICALLY INDIGENT ARE CHILDREN, 18 YEARS OF AGE AND UNDER, WHILE HALF ARE UNDER AGE 25. OVER HALF OF THE MEDICALLY INDIGENT WORK ALL OR PART OF THE YEAR, AND ALMOST HALF THE HOUSEHOLDS EARN $15,000 PER YEAR. THE SERVICES MOST UTILIZED BY THE INDIGENT INCLUDES: MATERNITY AND ACCIDENT-RELATED CARE, OBSTETRICAL SURGERY, NEONATAL CARE, AND SURGERY PERFORMED ON THE SAME DAY AS ADMISSIONS. I SHOULD ADD THAT INDIVIDUALS WITH ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) ARE LIKELY TO BECOME A SIGNIFICANT GROUP WITHIN THE MEDICALLY INDIGENT POPULATION, HOWEVER, STATISTICS ON THIS GROUP WERE NOT AVAILABLE AT THE TIME THE ABOVE DATA WAS COLLECTED.

IT IS PARTICULARLY NOTEWORTHY AND TROUBLESOME THAT MANY PEOPLE LACK ACCESS TO HEALTH INSURANCE UNDER OUR CURRENT SYSTEM, BECAUSE MOST INSURANCE IS EMPLOYMENT-BASED. AS NEW EMPLOYMENT TRENDS EMERGE, AND MORE PEOPLE WORK PART-TIME, IN TEMPORARY POSITIONS, OR FOR SMALL BUSINESSES, AN INCREASING NUMBER OF INDIVIDUALS AND FAMILIES WILL BE UNABLE TO OBTAIN HEALTH INSURANCE. MANY OF

THESE INDIVIDUALS AND FAMILIES COULD AFFORD HEALTH INSURANCE AT A GROUP RATE, BUT CANNOT AFFORD COVERAGE ON AN INDIVIDUAL BASIS. THE DATA DICTATES THAT WE GIVE THIS PROBLEM SERIOUS CONSIDERATION. THIS IS AN AREA OF PERSONAL INTEREST TO ME. AS A RESULT, I INTRODUCED LEGISLATION, RECENTLY SIGNED INTO LAW, THAT AUTHORIZES THE MARYLAND INSURANCE COMMISSIONER TO PROCEED WITH THE DEVELOPMENT OF A HEALTH INSURANCE PROGRAM FOR THE UNEMPLOYED AND THEIR DEPENDENTS. I LOOK FORWARD TO SEEING THE PROGRAM UP AND RUNNING IN MARYLAND.

THE JOINTLY FUNDED MEDICAID PROGRAM PROVIDES COVERAGE FOR LESS THAN 50 PERCENT OF THE NATION'S POOR. STATES, RESPONDING TO FEDERAL LIMITS ON FUNDING FOR MEDICAID IN THE EARLY 1980'S, TRIMMED ELIGIBILITY ROLES AND TIGHTENED ELIGIBILITY STANDARDS. RECENTLY, MANY STATES HAVE MOVED TO EXPAND MEDICAID COVERAGE FOR TARGETED POPULATIONS, HOWEVER, THERE REMAINS A LARGE GROUP OF THE POOR WHO ARE INELIGIBLE FOR MEDICAID. CONGRESS HAS, IN RECENT FEDERAL BUDGETS, BEEN CONSIDERATE OF THE STATES' DEPENDENCE ON MEDICAID AND HAS RESISTED ATTEMPTS TO REDUCE THE FEDERAL CONTRIBUTION TO THE PROGRAM SINCE 1983. HOWEVER, IT IS BELIEVED IN THE STATES THAT MEDICAID CONTINUES TO BE A TARGET FOR FUTURE FUNDING REDUCTIONS DESPITE SUCCESSFUL STATE EFFORTS TO CONTAIN PROGRAM COSTS.

THESE INDIVIDUALS, THE MILLIONS WHO LACK HEALTH INSURANCE, WHO ARE UNABLE TO PAY FOR INDIVIDUAL COVERAGE OR HEALTH CARE SERVICES, WHO CANNOT SEEK COVERAGE THROUGH EXISTING CHANNELS DUE TO HEALTH STATUS, INCOME, OR EMPLOYMENT STATUS, THESE PEOPLE WHO FALL THROUGH THE CRACKS OF OUR HEALTH CARE SYSTEM, SHOULD BE THE FOCUS OF OUR CONCERNS TODAY.

NATIONALLY, THERE IS NO SYSTEM TO TAKE CARE OF THESE PEOPLE. STATES, HOWEVER, HAVE SOUGHT THE ASSISTANCE OF LOCAL GOVERNMENTS AND THE PRIVATE SECTOR

TO FULFILL THEIR SOCIAL OBLIGATION TO PROVIDE ACCESS TO HEALTH CARE TO THIS POPULATION. OUR ATTEMPTS MAY BE INCOMPLETE, BUT STATES HAVE RECOGNIZED THE NEED AND MADE EFFORTS TO FILL IT.

OUR MAJOR CONCERN WITH THE "ACCESS" INITIATIVES PRESENTLY BEFORE THE CONGRESS IS THAT THE "ACCESS TO HEALTH CARE ACT OF 1986," LEGISLATIVE PACKAGE (S.2402, S.2403 AND H.R. 4742), SETS THE RESPONSIBILITY FOR FINANCING HEALTH CARE FOR THE INDIGENT SQUARELY ON THE SHOULDERS OF THE STATES WITHOUT A FEDERAL COMMITMENT TO ADDRESS THE PROBLEM OF EXTENDING ACCESS TO HEALTH CARE TO ALL THE NATION'S CITIZENS. FEDERAL MANDATES WITHOUT COMMENSURATE FEDERAL FINANCIAL ASSISTANCE DO LITTLE TO FOSTER AND ADVANCE THE STATE/FEDERAL PARTNERSHIP WHICH IS NECESSARY TO ULTIMATELY RESOLVE THIS NATIONAL PROBLEM. NCSL BELIEVES THAT A FEDERAL COMMITMENT TO ACTION WOULD INCLUDE THE NECESSARY FUNDS TO IMPLEMENT THE IDENTIFIED REMEDIES.

IN ADDITION, THIS PACKAGE OF LEGISLATION DOES NOT ADDRESS TWO MAJOR ELEMENTS OF FINANCING HEALTH CARE: CATASTROPHIC ILLNESSES AND LONG TERM CARE. STATES ARE SEEKING SOLUTIONS IN THESE TWO AREAS, HOWEVER, WITHOUT THE ASSISTANCE AND SUPPORT OF THE FEDERAL GOVERNMENT AND THE PRIVATE SECTOR, THE STATES WILL BE OVERWHELMED BY THE EXPENSE OF PROVIDING CARE IN THESE AREAS TO ALL WHO MAY REQUIRE IT.

FEDERAL MANDATES OF THE MAGNITUDE OF THOSE CONTAINED IN THIS LEGISLATIVE PACKAGE ARE USUALLY RESERVED FOR AREAS WHERE STATES ARE PERCEIVED TO BE INACTIVE OR REMISS IN THEIR RESPONSIBILITIES. FEDERAL MANDATES WITHOUT IMPLEMENTING FUNDS ARE ALWAYS ONEROUS. THIS PACKAGE WOULD INTRUDE IN AN AREA WHERE STATES HAVE TAKEN THE LEAD AND HAVE PROVIDED THE MOST INNOVATION AND WOULD PROVIDE NO

FEDERAL FINANCIAL ASSISTANCE TO GET THE JOB DONE. IN THESE RESPECTS, THE PACKAGE BEFORE US IS A TROUBLING ONE.

BRIEFLY, I WILL DESCRIBE SOME STATE INITIATIVES ON INDIGENT CARE AND ON UNCOMPENSATED HOSPITAL CARE. IN DOING SO, I WILL ALSO RAISE SOME OF OUR SPECIFIC CONCERNS WITH THE LEGISLATIVE PACKAGE BEFORE US. TODAY, I WANT TO OFFER CONSTRUCTIVE CRITICISM AND OFFER OUR ASSISTANCE IN DEVISING AN ADEQUATE SOLUTION TO THE PROBLEM.

CARE FOR THE MEDICALLY INDIGENT- STATE INITIATIVES

AS OF JULY 1985, 34 STATES HAD STATE INDIGENT CARE PROGRAMS, AND IN THE 16 OTHER STATES THAT DID NOT HAVE STATE PROGRAMS, COUNTIES AND MUNICIPALITIES GENERALLY HELD SOME LEGAL RESPONSIBILITY TO PROVIDE CARE TO THEIR RESIDENTS, ACCORDING TO A 1985 SURVEY OF STATE PROGRAMS BY THE INTERGOVERNMENTAL HEALTH POLICY PROJECT AT GEORGE WASHINGTON UNIVERSITY. THESE 34 STATES SPENT AN ESTIMATED $213 BILLION ON INDIGENT CARE IN FISCAL YEAR 1983. THIS FIGURE DOES NOT TAKE INTO ACCOUNT COUNTY CONTRIBUTIONS, OR SPENDING FOR SPECIFIC DISEASES OR POPULATIONS. NOR, DOES IT INCLUDE THE FUNDS COUNTIES PROVIDE HOSPITALS DIRECTLY TO OFFSET UNCOMPENSATED CARE.

EIGHTEEN STATES FUNDED THEIR INDIGENT CARE PROGRAMS TOTALLY FROM STATE REVENUES, 15 STATES FINANCED THE PROGRAMS JOINTLY WITH LOCAL GOVERNMENTS, USUALLY COUNTIES, AND 2 STATES ADOPTED ASSESSMENTS ON HOSPITAL REVENUES TO USE AS A STATE MATCH FOR EXPANSIONS IN THEIR MEDICAID PROGRAMS. THE STATE-LOCAL SHARE IN THESE PROGRAMS RANGED FROM 50 PERCENT STATE AND 50 PERCENT COUNTY, TO 92 PERCENT STATE AND 8 PERCENT COUNTY. WHILE MOST OF THE FUNDS FOR THESE

PROGRAMS ARE DERIVED FROM STATE GENERAL REVENUES, A FEW STATES RELY ON OTHER FUNDING SOURCES. IN ADDITION, STATES CONTRIBUTED $217 BILLION TO MEDICAID IN FISCAL 1985 AND ARE EXPECTED TO CONTRIBUTE $237 BILLION IN FISCAL YEAR 1986.

A MAJOR CATALYST FOR STATE ACTION ON CARE FOR THE MEDICALLY INDIGENT WAS THE RECESSION OF THE EARLY 1980'S, WHEN THE NATION EXPERIENCED A SLOWDOWN IN THE ECONOMY COUPLED WITH HIGH EMPLOYMENT. DESPITE THE ECONOMY'S UPSWING IN RECENT YEARS, THE NUMBER OF MEDICALLY INDIGENT REMAINS HIGH AND STATE CONCERN FOR THIS PROBLEM CONTINUES. NCSL, RECOGNIZING THE LEVEL OF THIS CONCERN BY STATES, HAS USED ITS RESOURCES TO ASSIST STATES IN THEIR ATTEMPTS TO DEVELOP SOLUTIONS TO THE PROBLEM. IN 1983, NCSL'S SPECIAL COMMITTEE ON HEALTH CARE COST CONTAINMENT, WHICH STUDIED THE PROBLEM OF CONTAINING HOSPITAL COSTS, ALSO REVIEWED THE SUBJECT OF STATES AS PURCHASERS OF HEALTH CARE BENEFITS FOR THE MEDICALLY INDIGENT AND IDENTIFIED AVAILABLE OPTIONS. THE MEMBERS AND THE CHARACTERISTICS OF THE MEDICALLY INDIGENT POPULATION VARY GREATLY BETWEEN THE STATES AND THE FISCAL IMPACT OF INDIGENT CARE INITIATIVES WILL AFFECT STATES DIFFERENTLY BASED ON EACH STATE'S FISCAL STATUS. STATES MUST BE AFFORDED MAXIMUM FLEXIBILITY TO ENABLE THEM TO RESPOND TO THIS PROBLEM AND OTHER PRIORITIES WITHIN THE STATE.

NCSL'S SURVEYS OF THE STATE LEGISLATURES FOR 1986 AND 1985 FOUND THAT CARE FOR THE MEDICALLY INDIGENT WAS THE SUBJECT OF EXTENSIVE LEGISLATION. IT WAS THE TOP LEGISLATIVE CONCERN FOR LEGISLATURES IN 1985. FIFTEEN STATES LISTED CARE FOR THE MEDICALLY INDIGENT AS ONE OF THE TOP THREE HEALTH ISSUES THEY WOULDCONSIDER IN 1986, AND 29 STATES INDICATED THEY EXPECTED LEGISLATIVE PROPOSALS. MAJOR LEGISLATION TO ASSIST THE MEDICALLY INDIGENT WAS PASSED IN SOUTH CAROLINA, TEXAS, AND WEST VIRGINIA LAST YEAR. OKLAHOMA INSTITUTED AN

INCOME TAX CHECK-OFF DESIGNATED FOR MEDICALLY INDIGENT CARE. GEORGIA AND SOUTH CAROLINA AUTHORIZED COLLECTION OF MEDICALLY INDIGENT CARE.

STATES HAVE ALSO SOUGHT TO INCREASE ACCESS TO THE INDIGENT BY EXPANDING MEDICAID SERVICES AND ELIGIBILITY AND BY CREATING PROGRAMS FOR THE "MEDICALLY NEEDY." ACCORDING TO A DECEMBER 1985 SURVEY OF CHANGES IN STATE MEDICAID PROGRAMS PUBLISHED BY THE INTERGOVERNMENTAL HEALTH POLICY PROJECT, 28 STATES EXPANDED ELIGIBILITY IN THEIR MEDICAID PROGRAMS LAST YEAR. IN ADDITION, 26 STATES ADOPTED POLICIES THAT PROVIDED FOR EXPANSION OF SERVICES. MUCH OF THIS EXPANSION WAS TARGETED TO "HIGH RISK" GROUPS SUCH AS LOW INCOME PREGNANT WOMEN AND CHILDREN. THE TREND TOWARD EXPANSION IN MEDICAID ELIGIBILITY BEGAN IN 1983 WHEN 15 STATES ADOPTED SUCH POLICIES, AND CONTINUED IN 1984 WITH 19 STATES EXPANDING ELIGIBILITY.

UNCOMPENSATED HOSPITAL CARE AND THE STATES

IN 1984, NCSL PUBLISHED, "12 QUESTIONS: WHAT LEGISLATORS NEED TO KNOW ABOUT UNCOMPENSATED HOSPITAL CARE," AND PRODUCED A VIDEO TO ACCOMPANY IT. NCSL PROVIDED A COPY OF THIS BROCHURE TO EVERY MEMBER OF CONGRESS AND WOULD ASK AT THIS TIME THAT A COPY OF THE BROCHURE BE INCLUDED IN THIS HEARING RECORD. AMONG THE SET OF ISSUES THE BROCHURE URGES LEGISLATORS TO CONSIDER AS THEY DEVELOP PROGRAMS TO ADDRESS THE UNCOMPENSATED CARE PROBLEM IS QUESTION TEN, "WHAT ISSUES SHOULD LEGISLATORS CONSIDER IN SHAPING APPROACHES TO DEAL WITH THE UNCOMPENSATED CARE PROBLEM?" THIS QUESTION FOCUSES ON THE CRITERIA THAT SHOULD BE USED IN EVALUATING OPTIONS. ACCORDING TO THE BROCHURE, LEGISLATORS SHOULD ASK, DOES THE PROGRAM: (1) MAXIMIZE COVERAGE OF THE TARGET POPULATION AND MINIMIZE COVERAGE OF THE NON-TARGET POPULATION; (2) MINIMIZE SUBSTITUTION FOR PRIVATE INSURANCE; (3)

PROMOTE COST CONTAINMENT; (4) ENCOURAGE INNOVATION AND COMPETITION? IN ADDITION, LEGISLATORS SHOULD CONSIDER ADMINISTRATIVE FEASIBILITY, POLITICAL REALITY, AND LAST BUT NOT LEAST, AFFORDABILITY.

MANY STATE LEGISLATURES HAVE ENACTED MEASURES TO ASSIST HOSPITALS INCLUDING RECENT MEASURES ADOPTED IN FLORIDA, SOUTH CAROLINA AND TEXAS. IN ADDITION, MARYLAND, NEW YORK, NEW JERSEY AND MASSACHUSETTS HAVE ADDRESSED THE ISSUE THROUGH RATE-SETTING. MARYLAND'S ALL-PAYOR HOSPITAL RATE SETTING SYSTEM ESTABLISHES RATES IN SEVERAL WAYS, BUT CHARITY CARE AND BAD DEBT ARE CALCULATED THE SAME WAY FOR ALL SYSTEMS. HOSPITALS ARE PAID FOR UNCOMPENSATED CARE COST AT THE LESSER OF: (1) THE PREVIOUS YEAR'S ACTUAL COSTS; (2) WHATEVER HOSPITALS REQUEST; OR (3) WHATEVER THE STATE RATE SETTING COMMISSION DETERMINES TO BE REASONABLE. THE STATE HAS RECENTLY DIRECTED THE STATE RATE SETTING COMMISSION TO STUDY ALTERNATIVE FINANCING ARRANGEMENTS TO PAY HOSPITALS FOR UNCOMPENSATED HEALTH CARE. ARIZONA USES THE PRUDENT BUYER APPROACH TO PURCHASE CARE FOR UNCOMPENSATED PERSONS, WHILE THE COLORADO MEDICALLY INDIGENT PROGRAM EARMARKS FUNDING FOR UNIVERSITY AND DENVER GENERAL HOSPITALS TO PROVIDE CARE TO THE MEDICALLY INDIGENT. CALIFORNIA, OREGON, TENNESSEE, AND WEST VIRGINIA CONSIDERED BILLS TO REIMBURSE HOSPITALS FOR SOME CHARITY CARE LAST YEAR. FLORIDA'S "MEDICAL ASSISTANCE TRUST FUND," RECEIVES REVENUES FROM A TAX ON HOSPITAL REVENUES. IN ADDITION THE STATE CONTRIBUTES $20 MILLION ANNUALLY. THIS PROGRAM RECENTLY WENT THROUGH A REVIEW BY THE LEGISLATURE, AS THE STATE DETERMINED WHETHER TO IMPLEMENT A MEDICALLY INDIGENT PROGRAM AND TO PLACE A HIGHER EMPHASIS ON PRIMARY CARE SERVICES WHICH EMPHASIZE EARLY DETECTION AND PREVENTION.

IN LIGHT OF STATE AND LOCAL GOVERNMENT AND THE PRIVATE SECTOR EFFORTS TO CONTAIN HOSPITAL COSTS, THE ACCESS PACKAGE ENCOURAGES INDIVIDUALS TO SEEK ALL HEALTH CARE SERVICES IN A HOSPITAL SETTING BY MANDATING STATES TO REIMBURSE HOSPITALS FOR CHARITY CARE. THIS IS INCONSISTENT WITH CURRENT STATE STRATEGIES PROMOTING LESS COSTLY ALTERNATIVES FOR PRIMARY, PREVENTIVE AND AMBULATORY CARE. WHILE THIS PACKAGE IS SURELY WELL INTENDED, IT IS LIKELY TO IMPEDE CURRENT STATE EFFORTS TO FOSTER COMPETITION AND TO CONTAIN HEALTH CARE COSTS. IN ADDITION, A SEPARATION MUST BE MADE BETWEEN CHARITY CARE, BAD DEBT, AND SUBSIDY OF HOSPITALS FOR "EXCESS CAPACITY."

RISK POOLS-STATE INITIATIVES

RISK POOLS APPEAL TO STATES BECAUSE THEY PERMIT THE PRIVATE SECTOR TO PLAY THE PRIMARY ROLE IN PROVIDING HEALTH CARE COVERAGE. ALL STATE RISK POOLS ARE EXPECTED TO BE SELF-SUPPORTING, HOWEVER EXPERIENCE HAS SHOWN THAT DUE TO THE CHARACTERISTICS OF THE PLAN PARTICIPANTS, SELF-SUFFICIENCY IS DIFFICULT TO OBTAIN. AS THE MORE HEALTHY PARTICIPANTS LEAVE THE PLANS DUE TO HIGH PREMIUM COSTS, PREMIUM REVENUE FALLS SHORT OF COVERING PROGRAM COSTS. THIS INCREASE MAKES THE PLANS COST PROHIBITIVE FOR OTHER PARTICIPANTS. IN ADDITION, WHILE THESE POOLS PROVIDE A VALUABLE SERVICE, THEY REACH A RELATIVELY SMALL SUBSET OF THE MEDICALLY INDIGENT POPULATION.

OF THE ELEVEN STATES THAT HAVE ESTABLISHED RISK POOLS, ALL BUT ONE RECEIVE DIRECT OR INDIRECT SUBSIDY FROM THE STATE. WISCONSIN'S PROGRAM, WHICH IS LIMITED TO HIGH RISK INDIVIDUALS, IS THE ONLY ONE THAT SUBSIDIZES PREMIUMS FOR LOW INCOME INDIVIDUALS. THE SUBSIDY IS FUNDED FROM THE STATE GENERAL FUND AND PROVIDES ASSISTANCE TO FAMILIES WITH INCOMES UP TO $16,500. IT IS NOT AN INCOME

MAINTENANCE PROGRAM, BUT ONE TO OFFSET THE EXTRA COST OF THE PREMIUM. PRESENTLY, 30 PERCENT OF THE PLAN'S POLICYHOLDERS RECEIVE A PREMIUM SUBSIDY FROM THE STATE. PLANS IN OTHER STATES RECEIVE STATE SUBSIDIES THROUGH TAX CREDITS. CONNECTICUT, WHICH DOES NOT HAVE A STATE INCOME TAX, PROVIDES NO SUBSIDY TO ITS RISK POOL PARTICIPANTS.

STATES THAT HAVE RISK POOLS HAVE BEEN ENCOURAGED BY THE WILLINGNESS OF PARTICIPANTS TO EMBRACE THE CONCEPT AND WORK OUT THE MECHANICS OF THE POOLING ARRANGEMENTS, BUT DISCOURAGED BY LOW PROGRAM UTILIZATION BY THE PUBLIC, NON-PARTICIPATION BY SELF-INSURERS, LIMITS ON THE BENEFIT PACKAGE, AND THE LOSSES THE POOLS HAVE INCURRED. IN MINNESOTA, THE PROGRAM COVERS OVER 10,000 PEOPLE, BUT HAS INCURRED SUBSTANTIAL LOSSES SINCE ITS INCEPTION IN 1976. THE MINNESOTA PROGRAM LOST APPROXIMATELY $5 MILLION IN 1985.

IN CONCLUSION, STATES HAVE BEEN AND WILL CONTINUE TO DEVELOP RESPONSES TO THE PROBLEM OF PROVIDING ACCESS TO HEALTH CARE TO ALL INDIVIDUALS. WE HAVE BEEN DEVELOPING PROGRAMS THAT ADDRESS THE SPECIFIC NEEDS OF INDIVIDUALS WITHIN THE STATES AND PROGRAMS THAT ARE COST EFFECTIVE AND MANAGEABLE. WE WOULD WELCOME FEDERAL INITIATIVES THAT WOULD SERVE TO ASSIST AND EXPAND AND ENCOURAGE ADDITIONAL STATE ACTIVITY. THE PROVISIONS IN THIS LEGISLATIVE PACKAGE COULD PLACE A CONSIDERABLE FINANCIAL BURDEN ON STATE GOVERNMENTS, UNDERMINING PROGRESS ALREADY MADE AND SLOWING ADDITIONAL PROGRESS. IN ADDITION, THE PENALTIES ON STATE PUBLIC HEALTH SERVICES ACT PROGRAMS AND MEDICAID, FOR FAILURE TO COMPLY WITH THE LEGISLATION ARE DRACONIAN AND WOULD HURT MANY OF THE SAME PEOPLE THE LEGISLATION IS DESIGNED TO ASSIST.

BELOW IS A SHORT LIST OF OBSERVATIONS WITH RESPECT TO THE ACCESS TO HEALTH CARE PACKAGE THAT NCSL WOULD LIKE TO SUBMIT FOR THE RECORD AT THIS TIME:

(1) THE LEGISLATIVE PACKAGE INAPPROPRIATELY PLACES PRIMARY RESPONSIBILITY FOR INDIGENT CARE ON THE SHOULDERS OF THE STATES.

(2) THE LEGISLATIVE PACKAGE, IF ENACTED, WOULD BE COSTLY TO THE STATES, AND NO ADDITIONAL FEDERAL FINANCIAL ASSISTANCE IS PROVIDED FOR.

(3) THE RISK POOL INITIATIVE MAKES NO PROVISION FOR GRANDFATHERING IN EXISTING STATE PROGRAMS AND COULD RESULT IN SUBSTANTIAL COSTS TO STATES THROUGH DIRECT OR INDIRECT SUBSIDIZATION.

(4) THE UNCOMPENSATED CARE INITIATIVE MAY ENCOURAGE USE OF HOSPITALS FOR PRIMARY AND PREVENTIVE CARE, DISCOURAGE COMPETITION AND FRUSTRATE STATE STATE AND PRIVATE SECTOR INITIATED COST CONTAINMENT EFFORTS, BY PROVIDING PREFERENTIAL TREATMENT TO HOSPITALS OVER ALTERNATIVE DELIVERY SYSTEMS.

(5) THE DEVELOPMENT OF ALTERNATIVE INSURANCE INSTRUMENTS FOR THE UNEMPLOYED, PART-TIME WORKERS, SEASONAL AND TEMPORARY WORKERS AND OTHERS WHO CANNOT AFFORD TO BUY INDIVIDUAL HEALTH INSURANCE SHOULD BE PURSUED BY THE FEDERAL GOVERNMENT AND GIVEN A HIGH PRIORITY.

(6) WAYS TO MAKE HEALTH INSURANCE MORE AFFORDABLE FOR SMALL BUSINESS OWNERS SHOULD BE INVESTIGATED.

(7) THE PROVISION THAT WOULD REQUIRE STATES AND OTHER EMPLOYERS TO CONTINUE TO PAY THE EMPLOYERS SHARE OF HEALTH INSURANCE FOR LAID-OFF WORKERS WILL BE COSTLY TO THE STATES.

I THANK YOU FOR THIS OPPORTUNITY TO SHARE OUR VIEWS WITH YOU ON THIS IMPORTANT LEGISLATIVE PACKAGE. I LOOK FORWARD TO WORKING WITH ALL OF YOU AS WE MAKE EVERY EFFORT TO MAKE QUALITY HEALTH CARE AVAILABLE TO ALL AMERICANS.

Prepared Statement of James L. Rout

Testimony of the Honorable James L. Rout, Chairman, Board of Commissioners, Shelby County, Tennessee, Before the Intergovernmental Relations Subcommittee, U.S. Senate Committee on Governmental Affairs,

June 26, 1986

Mr. Chairman and Distinguished Members of the Subcommittee:

It is a pleasure to appear before you this morning on behalf of the National Association of Counties (NACo), to offer some observations on S. 2403, the "Access to Health Care Act of 1986." Our Association and its over 2,000 member counties appreciate your courtesy in making this time available to us.

We are pleased to recognize your leadership in introducing S. 2403, Mr. Chairman, and commend you for your willingness to tackle this complex problem. Assuring access to needed health care for those who are currently denied it is a pressing national priority.

NACo has long been interested in the problem of access to health care in the United States. Its interest derives from both a commitment to the health and well-being of the constituents of county governments and from a concern over the escalating costs to counties in providing care to those who have nowhere else to turn for assistance. For the indigent and the poor, access to health care frequently means access primarily through the portals of county programs or financing.

Historically, counties have been the providers of last resort for the health care of the poor and indigent. We operate an extensive network of county hospitals and public health services, clinics and nursing homes which directly deliver treatment to people who are uncovered by insurance and lack the means to finance their own care. In Memphis, Shelby County, Tennessee, we put almost $60 million in our two nursing homes and public hospital to make up the financial shortfall that results annually due to those patients who cannot pay or can pay only a small portion.

We know the problem of access to health care, because it is at the county level that the "rubber hits the road." We see the problem every day--in very human terms. Uncompensated care is a major social dilemma facing our nation. And the problem is not getting better. It is worsening.

According to a report just released by the Catholic Health Association,

> Growing evidence shows that the gap in the U.S. health care net has become larger. Since 1979, the number of persons potentially unable to pay for health care has been rising steadily. Between 1980 and 1982, those with family incomes 150 percent below (sic) the poverty income level increased by 13.5 percent; the number of inadequately insured, having either no insurance or private nongroup insurance only, grew by 7 percent. Medicaid coverage stayed essentially constant but fell as a proportion of all low income people, from almost 36 to 31 percent. Even more dramatic, persons both poor and inadequately insured increased nearly 21 percent; this population presumably depends more on free care to meet their needs for hospital services.

These are the people, 37.1 million of them, Mr. Chairman, who end up in hospital emergency rooms seeking non-emergency care. These are the expectant mothers who delay vital prenatal care; the homeless; the unemployed; the mentally ill; the aged too proud to seek help until desperation drives them to it. Every day in every county in America the problem of lack of access to adequate health care reveals itself in stark human terms.

But, Mr. Chairman, what are counties to do? Despite the legal theory of government having "deep pockets" and an unlimited ability to pay, the fact is that county treasuries are hard pressed to pay the bills of indigent and poor patients. County hospitals tend to be old facilities needing major repair. But we are constrained in our ability to pay or to capitalize rennovations and expansion of facilities by factors beyond our control. We cannot continually replenish our resources because our taxing power is too often constitutionally limited or stretched to the breaking point. Our taxpayers, through their local ballot, have sent us the clear message that their willingness to pay has practical limits.

NACo believes that the problem is national in scope, despite regional variations in severity. And, as a national problem, the issue of access to care demands a national solution. That is why our Association's fundamental policy document, The American County Platform, argues for a Federal system of financing health care. To quote the Platform, we believe,

> The financing mechanism must be a broad-based national tax system. Delivery of care should not be permitted

> to reflect the widely varying capacities of local economies to finance health care services. Access to basic care should not be a function of the local economy or income. . . . The program must provide a required basic level of coverage to all residents of the United States. . . . The financing method must be at a level of spending responsive to health needs and to the rate of inflation, neither freezing expenditures at current levels nor leading to excessive future investment in health services.

Having said this, however, we must recognize that the current climate of opinion does not embrace our position or permit dramatic movement toward its realization. You, yourself, Mr. Chairman, made the observation when you introduced S.2403 that there "are no universal approaches--no 'magic bullets.' Concepts such as federally administered national health insurance or nationally mandated all-payer insurance systems are impractical, politically unpalatable, and just plain won't work." Other theories now dominate the debate and we have no wish to tilt at windmills.

Thus, Mr. Chairman, we are appreciative of the efforts you and your colleagues have made to address the problem of access to care within a politically realistic framework. If S. 2403 is not the optimum solution in our judgment, it is still a significant point of departure for making some progress toward our common goal of assuring all Americans a fundamental right to adequate health care. It may, in some sense, be a proximate solution, but S. 2403 is certainly preferrable to no solution at all.

And so, despite our philosophical reservations, NACo would like to commend you for a worthwhile initiative which merits the careful examination of the Congress. S. 2403 offers another option in the ongoing debate, an alternative that will surely expand our awareness of the range of choice before us.

As you deliberate on this measure, we would direct your attention to several provisions:

In Section 2, state and local governments are specifically exempted from the definition of "large employer" in Section 4912 of the Internal Revenue Code, for purposes of imposing a tax on expenses of health plans. Without the exemption, local governments would be faced with yet another mandate with significant cost implications, at a time when traditional revenue sources are drying up. Faced with the possible elimination of General Revenue Sharing, which many counties use to finance improved access to health care services for the poor, the imposition of an additional cost would seem to work at cross-purposes and create a double hardship on county governments.

But this excise tax provision was intended to reach large employers who self-insure and are exempt from state regulation under ERISA. Many counties, Mr. Chairman, also self-insure and are uncertain about their status under this proposal. They seem to be neither fish nor fowl--exempt from the tax and from mandatory participation in the pool. So we would be grateful for further clarification of the status of self-insuring governmental entities and the provisions of S. 2403, which might impact on them.

We believe this Subcommittee should carefully review the experience with risk pooling in those states which have enacted such legislation. It may be that such pools do not provide the anticipated results because of prohibitive participation costs for intended beneficiaries. There is some data which suggests that underutilization may not make the dance worth the dime.

Florida is a case in point. One of the 9 states currently operating risk pools, Florida enacted its comprehensive health insurance statute in 1982. By the end of 1985, only 257 policies had been sold . Indiana had only 3,069 enrollees in its plan as of April, 1984--four years after enactment. Similar figures in the other states suggest that risk pooling will leave us a long way from providing coverage for the 37.1 million Americans who have fallen through the cracks in our social safety net.

If the pool only attracts those individuals at high risk, the adverse selection factor could defeat the best of cost containment efforts. In general, a community-rated system that spreads risk across a larger population seems more desirable than one which concentrates high risk individuals in a health care ghetto.

We recognize that, in your home state of Minnesota, Mr. Chairman, over 10,000 people have benefitted from the state-run pool. But even with this success story, it must be acknowledged that the pool only reaches a small percentage of those who need coverage. With a $1,000 deductible and premiums running to $1,200 per year, only those with the means to participate can do so and presumably those with the highest health risk will have the greatest incentive to join. Perhaps that is why in Minnesota substantial losses have been incurred by the risk pool in every year since its inception--losses ranging from a ratio of 236% in 1981 to 151% in 1984. (Loss ratio is the percentage of claims incurred to earned premiums.) We agree with your assessment that "Obviously, this alternative is not for everyone, but it surely has made a difference for many Minnesotans." We believe it is important to keep in mind that the risk pool is not a panacea, but is part of a larger whole, each part of which is important to the goal of achieving the stated objective of this legislation.

One wonders, as well, at the impact of a risk pool on traditional insurance coverage. Would the existence of such a pool tempt third-party payors to exclude certain coverage or skim low-risk clients, leaving the pool to absorb ever-increasing numbers of high cost beneficiaries? In Wisconsin, which has a risk pool modeled after Minnesota's, a 1984 survey of subscribers indicated that 97% were eligible to participate in the plan because they had been rejected by two or more insurers and 42% rated their health as less than good. Not surprisingly, Wisconsin's pool failed to achieve its objective of becoming self- sufficient after three years and has had to increase its premiums to as much as $1,836 per year. Such experiences prompt us to ask what incentives a risk pool provides for expanding opportunities for the uninsured to become part of the traditional insurance network? What assurances can be made that insurors will not "dump" more high-risk subscribers into the pool?

The mandate that states develop programs for the uninsured and underinsured or face a possible Medicaid penalty is a two-edged sword. Counties certainly applaud efforts to create coordinated and comprehensive approaches to the provision of indigent care, but we are apprehensive about the form state programs may take. We cannot predict the impact of such programs on local governments without knowing the details of specific state implementation plans. To the degree to which state programs for indigent care spread the burden equitably, to that degree we would tend to be supportive. But we do not know if a state will finance its indigent care program through a "sick tax," general fund revenues, state-local match, or any of a variety of other mechanisms and are therefore cautious in embracing what may turn out to be a porcupine.

The imposition of a Medicaid penalty for non-compliance also strikes us as counter- productive. Even though the penalty might be restricted to the administrative payments, it will still have a negative impact on beneficiaries through delays and disruptions in eligibility determinations, claims processing, and service delivery. Since Medicaid is so vital to the poor's limited access to health care, cutbacks for non-compliance with the state indigent care program mandate seem a peculiar remedy indeed. The cure for the problem is to improve access, not reduce it even more.

As employers, counties share a concern over the cost implications of extending coverage to workers who are laid off or who work reduced hours "under the same terms and conditions" as if they were still fully employed. This provision could conceivably mean 100% payment of premiums where counties have negotiated such benefits for their employees. Extending the time limits and possible coverage of widowed or divorced spouses and children accelerates our fiscal concerns.

Mr. Chairman, many of our counties are faced with serious financial problems. Where property tax revenues have dropped through devaluation of land, where voters have refused to approve increased levies, or where levies have bumped up against constitutional limitations, counties have been forced to reduce their work forces to meet their fiscal obligations or absorb cutbacks in Federal assistance. We recognize the humanitarian instincts which prompt proposals to continue group coverage of laid-off workers and their families, but there is a price tag to such initiatives. Any mandate of this type, without Federal participation in the costs, may prove truly burdensome for financially-strapped counties. And such counties are the very ones most likely to confront the problem because their revenues cannot support continuation of existing work forces.

In summary, NACo views S. 2403 as a positive and creative contribution to the dialog over the issue of providing access to health care for the uninsured and underinsured. We will be reviewing your proposal in greater depth at our forthcoming Annual Conference in mid-July. But in the absence of any change in policy by our membership, we must reaffirm our belief that national financing of our health care system is the most direct and preferred approach to assuring access to health care for the people of our nation. That remains NACo's long-term objective, despite the current temperament which weighs against it. In that regard, we endorse your view that "as long as the objective is not forgotten and the process to get there is not forsaken" then stopgap measures remain worthy of our consideration.

America's county governments are sympathetic to your goals and open to further discussion of various chosen means to attain those goals. We offer our comments and reservations in a spirit of cooperation and gratitude for your efforts to address an enduring social problem of growing magnitude. NACo hopes you will call on us in the future if we can be of assistance to you in your deliberations on this issue.

Prepared Statement of Jack W. Owen

INTRODUCTION

Mr.. Chairman and members of the Committee, I am Jack W. Owen, Executive Vice President of the American Hospital Association. The highest priority for our Association, which represents 5,600 institutional and 40,000 personal members, is finding a solution to the growing crisis of medical indigence. In February of 1986 the AHA Board's Special Committee on Care for the Indigent completed its report, Cost and Compassion: Recommendations for Avoiding a Crisis in Care for the Medically Indigent, which outlines a series of long- and short-term public and private initiatives which could be adopted to address the problem. Many of the approaches we recommended are also proposed in the Access to Health Care Act of 1986 (S.2402/S.2403/H.R.4742). For this reason, we applaud the sponsors' efforts, we consider the proposed bills an important first step toward solving the problem, and we welcome the opportunity to present our views on this high-priority issue.

In concept, these bills can provide a good beginning toward our shared goals of averting the indigent care crisis and assuring that those in need have adequate medical care. As with any legislation, however, they will benefit from the close scrutiny and fine-tuning that the legislative process affords, and therefore we have several recommendations of ways the bills might be strengthened and improved.

THE EMERGING INDIGENT CARE CRISIS

Twenty years after the creation of Medicaid, medical indigence is again becoming a major problem for a large and increasing number of Americans, and therefore a major policy issue for federal, state, and local government, providers, and consumers of health care services. A sizable percentage of the population is unable to obtain private insurance and does not qualify for public insurance programs. The persistence of a large population without adequate health insurance coverage imposes large costs on all members of society.

In February 1985, the Board of Trustees of the American Hospital Association established a Special Committee on Care for the Indigent to document the nature and magnitude of the indigent care problem, and to recommend AHA policy initiatives to address this issue at the local, state, and national levels. The committee undertook a comprehensive review and analysis of the causes, manifestations, and consequences of the problem and recommended a variety of long- and short-term actions that government, businesses, insurers, and providers could take to solve it. The final report of the special committee, Cost and Compassion: Recommendations for Avoiding a Crisis in Care for the Medically Indigent, was accepted by the Board at its February 1986 annual meeting, and will be sent to members of this committee upon its publication in July.

The report shows a problem of startling and growing dimensions:

- The size and characteristics of the uninsured. In 1983, nearly 33 million Americans were without private health insurance or were not covered by governmental health benefit programs. Nearly two-thirds of the uninsured were employed or were members of families in which the head of the household was employed and often insured. However, the jobs held by the uninsured are frequently marginal. Two-thirds of the uninsured have family incomes less than twice the federal poverty level and one-third fall below the federal poverty guidelines. These characteristics have an important bearing on the extent to which private insurance can resolve the problem of medical indigence.

o The inadequacy of Medicaid. Although Medicaid is often thought to be the principal means of financing care for the indigent, it now covers less than 40 percent of the poor. Medicaid must now be viewed principally as a program of supplementary coverage for the aged and disabled medically indigent who are eligible for and receive benefits under Medicare.

In 1984, barely one-fourth of Medicaid's expenditures paid for care needed by the non-Medicare eligible poor. Three-quarters of Medicaid's expenditures paid for services provided to individuals already covered by Medicare: primary care and other acute care services not covered by Medicare; extended long-term care for Medicare beneficiaries; and Medicare Part B premiums.

o Rapid growth of unsponsored care. At the same time that Medicaid has been providing coverage for a declining percentage of the poor, the amount of uncompensated care provided by hospitals has risen sharply.

State and local government tax appropriations have not kept pace with the growth in uncompensated care. Unsponsored care--the care that must be subsidized by the private sector--more than doubled between 1980 and 1984. In 1984 unsponsored care amounted to $5.7 billion or 4.6 percent of total hospital expenses, up from 3.6 percent of total expenses in 1980.

- Declining sources of private subsidy. Traditionally, hospitals have been compelled--and have been able--to subsidize the cost of care provided to the medically indigent by increasing charges to privately insured patients and patients able to pay their own bills. Between 1980 and 1984, the ability of hospitals to subsidize non-paying patients declined sharply. The principal sources of government financing, Medicare and Medicaid, provide no subsidies for the costs of indigent care. As competitive pressures on private insurers and providers increase, private sources of funds will continue to diminish.

The committee concluded that these trends threaten to limit access to care by the poor and therefore jeopardize the viability of the competitive approach to health care. In an increasingly competitive industry, those hospitals serving substantial numbers of the indigent will be unable to survive without explicit public support. If a method of financing care for the medically indigent within a competitive system cannot be found, pressures to return to more regulatory methods may be irresistible. The committee recommended a variety of long- and short-term measures to avert this crisis.

SOLVING THE INDIGENT CARE PROBLEM: LONG-TERM APPROACHES

Medical indigence is a complex, multi-faceted issue that has no single, or simple, solution. Because the public expects needed care to be provided regardless of a patient's ability to pay, all members of society must participate in the financing of care provided to the medically indigent. This public responsibility does not mean, however, that government alone can or will resolve the problem. An enduring solution to the problem of medical indigence will require initiatives by both the public and private sectors to:

- o reduce the size of the medically indigent population through adequate private health insurance; and

- o restructure and extend public programs to finance care for the medically indigent who are unable to obtain private insurance.

Private insurance can be made more widely available through the cooperative efforts of federal, state, and local government, private insurers, employers, and providers. However, as competition increases and resources become more constrained, a residual public program is essential to finance care for those who cannot obtain private health insurance. To strengthen the public financing of care for the medically indigent, several actions should be pursued:

- o The reorganization of Medicaid into three distinct programs: a program of acute care coverage for the medically indigent who are not eligible for Medicare; a program of supplementary acute care coverage for Medicare beneficiaries; and a program of long-term care coverage for Medicare beneficiaries.

- The gradual strengthening of the federal role in funding Medicaid: a Title XIX trust fund sponsored by a broadly based tax, for example a payroll tax. Such a tax could provide a stable source of funding for Medicaid, would equitably distribute the cost of the program, and, properly structured, could create a positive incentive for employers and employees to obtain private health insurance.

- Reform of delivery and payment systems: the adoption of innovative payment and delivery arrangements would encourage the efficient use and production of the health care services needed by individuals enrolled in Medicaid.

AVERTING THE INDIGENT CARE CRISIS: SHORT-TERM INITIATIVES

Although the elements of a long-term solution to the problem of medical indigence can be readily identified, adoption and implementation of a comprehensive solution will take time. It is essential that there be no deterioration of existing programs during these deliberations. Moreover, while the debate over the long-term solution proceeds, the issue should be dealt with through a series of incremental steps that strengthen incentives to provide employer-paid health insurance and that gradually strengthen public programs.

Initiatives to Promote Private Insurance

The federal government should strengthen, and not reduce, tax incentives that encourage adequate private insurance.

- o Personal income tax incentives: Individuals should be permitted to exclude employer-paid health insurance premiums from taxable income, or to deduct employee-paid health insurance premiums from taxable income, only if the health insurance policy covers all dependents. Current limitations on the tax deductibility of employee-paid health insurance should be rescinded, and the deduction should be made available to all individuals, not just those who itemize deductions.

- o Corporate income tax incentives: Health insurance premiums should be deductible as a business expense by employers only if the employer pays for coverage of dependents or offers employees the opportunity to purchase such coverage.

In addition, to address the problems created by the loss of health insurance coverage during periods of temporary unemployment, employers should be required to continue insurance coverage for laid-off workers as part of unemployment compensation.

States should encourage the formation of multiple-employer insurance arrangements in an effort to extend insurance to the self-employed and to employees of small firms.

Private insurers, employers, and providers should work to create innovative financing and delivery systems that increase the availability of affordable insurance, particularly for small employers.

Initiatives to Improve Public and Private Funding

Under no circumstances should the federal government reduce the level of federal funding available to state Medicaid programs, nor should it mandate or allow states to reduce entitlement under Medicaid. In addition,

- The expansion of Medicaid eligibility should be accomplished as federal resources permit, with the objective of achieving a uniform standard of eligibility under state Medicaid programs by 1990.

- The federal government should phase in the long-term reforms in Medicaid described above, including the creation of a stable, dedicated source of funding.

- To encourage provider participation in Medicaid and to eliminate the need for private-sector subsidies of Medicaid expenditures, Medicare and Medicaid payment levels generally should be comparable to those for private patients, that is, the ratio of payments to costs should be approximately the same for public and private payers, although the methods of payment may be different.

States should maintain eligibility and funding levels for Medicaid and other programs designed to finance care for the indigent. As their resources permit, states should expand Medicaid coverage to include both the medically needy and other segments of the medically indigent population.

States should establish risk pools for high-risk or uninsurable individuals. All insurers should participate in such risk pools, including Blue Cross plans, commercial insurers, and self-insured businesses. The federal government-should facilitate this by modifying the exemption of self-insured employers from state laws regulating the business of insurance.

Local government should maintain or increase funding for public or other government-supported providers. Within metropolitan regions, governments should identify methods of expanding the population base responsible for funding public providers. Local government should also evaluate the possible benefits of adopting formally organized systems for delivery of care. Employers and insurers should work with government to ensure adequate funding for the medically indigent who must rely on public support. If adequate public funding is not made available, employers should work with providers and insurers to establish funding mechanisms for care provided to the medically indigent.

Hospitals should maintain their historical commitment to provide care to those who need care, including the indigent; should take appropriate actions to raise public awareness of the implications of purchaser actions on the ability of the hospital to care for the medically indigent; and should work with employers, insurers, and government to develop viable short- and long-term solutions to the problem of medical indigence.

AN IMPORTANT FIRST STEP:
THE HEALTH CARE IMPROVED ACCESS ACT OF 1986, S.2402 and S.2403

S.2403, like its similar companion bill in the House (H.R.4742), takes the form of an amendment to the Internal Revenue Code; S.2402 contains many of the same provisions but takes the form of an amendment to the Public Health Service Act and does not include the section (Sec.5) on deducting group health plan contributions by self-employed individuals. All three versions include variations of several approaches recommended by AHA's special committee, although we have some reservations about each of the bills.

Sec. 2: Incentives for the Establishment of Statewide Insurance Pools

Description

This section would require large non-governmental employers (over 20 employees) who offer a group health plan to belong to a "qualified" state pooling association or to purchase insurance from an entity that does. Non-complying employers would face an excise tax (S.2403/H.R.4742) or civil penalty (S.2402) equal to 10 percent of the employer's annual health care expenses.

A "qualified pooling association" would be a nonprofit corporation established under state law, open to membership by insurers, hospital and medical service plan corporations, HMOs, employers, and other health financing entities. It would offer to any state resident not eligible for Medicare a level of insurance coverage typical of that provided through large employer groups, with specific federal minimum standards regarding out-of-pocket expenditures, maximum lifetime benefit, etc.

The pooling association would charge a pool premium rate expected to be self-supporting based upon "a reasonable actuarial determination of anticipated experience and expected expenses," but in no event to exceed 150 percent of average state premium rates for individual policies with comparable coverage. Any losses would be assessed equitably among all participating members. States or other entities could provide part or all of an enrollee's premium, based, for example, on the enrollee's income.

Comments

This proposal has several advantages. First, it would spread the cost over a fairly wide base, including self-insured businesses. Because the tax or civil penalty would be imposed under federal rather than state law, self-insured plans could not be exempted through ERISA. Second, it would insure not just high-risk individuals, but anyone able to pay the premium and, at the option of the state, some of the working poor and/or unemployed as well. As in AHA's approach of an expanded Medicaid plan, a large number of enrollees would be able to pay their own way. Third, small firms (who might find the tax particularly burdensome) would be excluded from the requirement.

As currently written, the bills have several problems, however:

- o In contrast to AHA's approach, the bill would place the burden on already-insured firms without taxing uninsured firms. To the extent that state plans include subsidized premiums, the result would be that companies that insure their employees could be subsidizing those that do not, and insurers could be subsidizing a product that competes with their own. This could tempt some firms to drop their insurance coverage and some private insurers to back away from the individual and small group plan market. The bills should be amended to provide some sort of comparable tax incentive to these non-insuring firms. The committee also should take care that the state pools are constructed in such a way that they do not result in less access to private insurance on the part of individuals and small groups.

- o The proposal would exempt federal, state, and local government agencies from the pooling requirements, which again would increase the burden for insured employers. We suggest that the Committee reconsider the appropriateness of such an exclusion, since it seems inequitable to ask insurers and insured businesses alone to be at risk for any necessary subsidy of the state plan.

- o The excise tax compliance mechanism in S.2403 would be preferable to the cumbersome civil penalty procedure described in S.2402, but the excise tax provision has two problems. First, employers in states that fail to set up a risk pool (and employers who opt out of risk pool membership) would be taxed under S.2403, yet the tax money would not necessarily be targeted to the medically indigent. The bill should specify that federal tax money collected under this authority would be earmarked for programs addressing the health care needs of the medically indigent in those same states. Second, employers would not be able to determine in advance what their "assessment" to cover losses would be, so they might be tempted to avoid the risk by paying their 10-percent tax, an outcome that would be particularly unfortunate if the tax revenues are not earmarked for health care. This could be remedied by establishing the equivalent of the 10-percent tax as a ceiling on any particular employer's assessment.

Sec. 3: Requiring State Plans for Payment for Uncompensated and Charity Inpatient Care

Description

Sec. 3 would require states to either establish uncompensated care plans or provide, through an HMO or other mechanism, health care coverage to all residents, thereby making an uncompensated care plan unnecessary. The state uncompensated care plan would have to provide for payment for unreimbursed costs incurred by each hospital in furnishing medically necessary inpatient and outpatient services, but the state would have considerable flexibility regarding how such costs would be determined. Payment could not be provided for care counted toward a hospital's Hill-Burton obligations, or that relates to "obligations to pay taxes," or for care to Medicare or Medicaid patients.

Also disqualified would be care for which charges can reasonably be expected to be collected with suitable collection mechanisms. The plan could not establish a legal or regulatory limit on the amount of charity or unreimbursed care a hospital may provide. The bill does not specify the financing mechanism a state should adopt, but merely requires that it be "adequate."

At the state's discretion, the plan could limit reimbursement for small (under $250) unpaid deductible or coinsurance bills; require continuation of state and local taxes previously allocated to charity and unreimbursed care, at the levels in effect in 1985 (with appropriate adjustments for inflation, etc.); and require that hospitals participating under the plan provide a certain level of charity and unreimbursed care and meet minimum standards in its efforts to collect unpaid bills.

Under the House bill, this section would be enforced by denying Medicare payments to hospitals in states that have not established a charity and uncompensated care pool, as a condition for receiving Medicare. S.2402 would deny Public Health Service Act funds, while S.2403 would reduce the level of federal financial participation for state Medicaid administrative costs from 50 percent to 25 percent, and ultimately to zero.

Comments

This section's "mandating" approach may be tolerable as a short-term, stop-gap solution, but only if it is structured carefully so that the costs are broadly spread, and only if it is accompanied by some evidence of good faith effort at the federal level. Otherwise, Medicaid coverage of the poverty population might drop still further below current 38 percent levels. Of the two alternative solutions contemplated in this section--state-financed care for the medically indigent and creation of uncompensated care pools - the first is clearly superior because it could make possible a broader and more equitable financing base and a more cost-effective delivery system. Unfortunately, the bills offer no details on this first alternative and no offer of federal support for implementing it. The bills should be amended to permit states to build on the existing Medicaid program to fulfill the requirements under this first alternative. For example, states could be required to provide Medicaid coverage, with federal financial participation, to designated subgroups living below designated percentages of the federal poverty levels. (S.2333, which would enable states to cover all infants and pregnant women under the federal poverty level, provides one example of how this might be done.)

The bills provide somewhat more detail on the uncompensated care pool option, but we believe they contain some serious problems and ambiguities:

- Under the house bill, a state might refuse to set up a plan and thereby deny Medicare beneficiaries access to hospital care. Such an outcome obviously would not be in anyone's interest, and, for this reason, the enforcement mechanism of either of the Senate bills would be better than the House version.

o Under all three bills, a state could enact a provider tax to fund the plan and then discontinue or drastically reduce state and local tax support for indigent health care. The maintenance of state and local tax efforts should not be a state option but should be part of the definition of a "qualified" plan. Moreover, the method of financing uncompensated care plans should be more clearly delineated to ensure that responsibility does not lie solely with hospitals but is shared among all sectors of society. Hospital taxes may work severe hardship on hospitals serving large numbers of Medicare and Medicaid beneficiaries, as any tax must be shifted to privately insured patients.

o The plan would be required to cover only hospital costs, so there would be no incentive for the development of alternative delivery systems. The AHA believes that uncompensated care plans should cover primary as well as hospital care, but only if responsibility for funding the plan is broadly spread. Spelling out an equitable and adequate financing plan would enable plans to appropriately cover these primary care costs.

o The bills do not define "adequate" payment levels; they permit states to establish their own criteria for how "unreimbursed costs" will be determined; and they permit states to set certain levels of charity care as a condition of participation. In combination, these provisions could force hospitals to choose between receiving no support under the plan and receiving very inadequate state payment for a much higher required volume of charity care. We believe the language of the bills should be more precise in the delineation of "adequate" payment levels.

- Some of the other language in the bills would also have to be more precise, to avoid inappropriate regulatory interpretations. For example, the bill should be more exact about what kinds of bad debts would be reimbursable. Community pressures--and hospitals' own ethical concerns--preclude hospitals from using many bad debt control and collection procedures commonly, and appropriately, used by other business.

- The bills are not clear about what the exclusion of reimbursement for "obligations to pay taxes" means. One possible interpretation is that the bills are anticipating enactment of state laws that require a hospital to provide some specified amount of charity care as a condition for receiving tax-exempt status, and is precluding hospitals from receiving reimbursement for any such legally mandated care. This would be very inappropriate, for two reasons. First, any such law would constitute a narrow misreading of the "charitable" mission of hospitals, which properly includes not only indigent care, but also health care for the non-indigent and a myriad of other social and educational services for the community at large. Second, such an exclusion (like the bill's exclusion of Hill-Burton obligations, which we also consider inappropriate) ignores a fundamental fact about unsponsored care. Unsponsored care provided to fulfill a legal obligation costs a non-profit hospital just as much as unsponsored care provided to fulfill a hospital's own mission. In either case, the hospital must pass these costs along to private payers, or, if it has few private payers, deplete its own assets and therefore jeopardize its ability to continue to serve the population as a whole.

If the bill in fact is referring to an exclusion of new legally mandated charity care, therefore, we would object, just as we object to its exclusion of Hill-Burton obligations.

Sec. 4: Temporary Extension of Coverage for Laid-Off Workers and Open Enrollment for Spouses of Unemployed Workers

Description

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires, as a condition for deductibility of employer contributions to health care plans, that all employers (including self-insured plans and state and local governments) with more than 20 employees provide 18 months continuation coverage for terminated employees and their dependents. Employers are not required to pay for such continuation coverage, however.

Sec. 4 of the proposed bills builds on these changes, extending the continuation coverage period from 18 months to 22 and requiring that premiums for the first four months be paid as they were before the termination. The bills also attempt to close another coverage gap by requiring an open enrollment period for an employee and spouse whenever a spouse employed elsewhere loses a job and therefore loses individual or family coverage.

Comment

AHA believes that the provision of continuation coverage is an important step in addressing the insurance problems of the short-term unemployed, and therefore we are pleased with the changes introduced by COBRA, the proposed extension of continuation coverage to 22 months, and the open enrollment period for employees and spouses following a spouse's job loss.

We also support, in principle, the proposal to require that the employer share of the premium be continued for the first four months, because employees who lose their jobs are seldom in a position to continue such payments on their own. On the other hand, we have some concern that this requirement could prove a hardship to some employers, particularly those in the 20-49 employee range, and therefore could lead some employers to lower their customary premium contribution for all employees, or even to drop their insurance coverage altogether. We suggest finding a way to keep this provision while guarding against some of these potential unintended side effects. For example, the bill might grant hardship exemptions to companies meeting certain tests, such as businesses with 20-49 employees and either very high employee turnover or very low profits.

Sec. 5: Deduction Allowable for Certain Group Health Plan Contributions by Self-Employed Individuals

Description

Sec. 5 of S.2403 would amend the Internal Revenue Code to permit self-employed owners of small businesses to take as a business deduction the cost of their own individual or family health insurance coverage. There are several restrictions to this: (1) the deduction cannot exceed the taxable income the employer receives from the business activity; (2) the health plan offered must benefit all full-time permanent employees not covered by another group health plan; (3) the employer's deduction cannot exceed the lowest employer contribution toward the premium of other employees in the same category (i.e., individual vs. family coverage); (4) the health plan may not be a self-insured one; and (5) one-half of the participants in the plan must be people who are not self-employed employees or their family members.

Comment

Self-employed workers, including those who operate small businesses, are a very significant component of the uninsured population, and therefore AHA supports this effort to make it easier for such individuals to insure themselves and their families. However, we believe this measure will be only a step toward solving the problem, because the key issue for most small businesses is their inability to find health insurance at affordable rates.

Sec. 6: Demonstration Projects on Improving Access to Health Insurance for Small Employers and Self-Employed Individuals

The final report of AHA's Special Committee on Care for the Indigent recommends a variety of actions that state and local governments, insurers, employers, and providers could explore to lower the cost of health insurance for small businesses and the self-employed. For these reasons, we were pleased to see that Sec. 6 of the proposed bill authorizes the conduct of studies and demonstration projects on ways to reduce health insurance costs for these groups. On behalf of our membership, we want to express our strong interest in contributing to these efforts.

CONCLUSION

I appreciate this opportunity to meet with the committee on this important piece of legislation, and I applaud the sponsors for their foresight and interest in the indigent care problem. We consider the Access to Health Care Act of 1986 (S.2402/S.2403/H.R.4742) an important first step. Although passage of these bills, with appropriate amendments, will help avert an immediate crisis in health care for the medically indigent, it is important to keep in mind that this legislation, by itself, is only a beginning. All members of society must participate in the financing of care provided to the medically indigent. An enduring solution to the problem of medical indigence will require initiatives by both the public and private sectors.

We look forward to working with the committee to strengthen and improve the Access to Health Care Act of 1986.

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July 22, 1986

Senator Dave Durenberger
Attention: Dr. Thomas G. Rundall
154 Russell Senate Office Building
Washington, D.C. 20510

Dear Dr. Rundall

In response to your question concerning the expansion of Medicaid, it is possible to identify several courses of action. The AHA envisioned a gradual expansion of eligibility criteria along two dimensions. First, the federal government should gradually move to a uniform standard of eligibility applied across states. Currently there are wide variations in Medicaid eligibility criteria resulting in wide variations in the proportion of the poverty populations covered in each state. The adoption of a uniform federal standard, possibly adjusted for cost-of-living differences, should be mandatory. Second, although infants and pregnant women would be, for the most part, covered under the provisions of S.2333, there remain other gaps in coverage, particularly for children and young adults.

These coverage gaps could be addressed in the near term by adopting some of the recommendations of the Southern Governors' Association that were not reflected in S.2333. Specifically, states also should be given the option to increase coverage for individuals who currently "fall through the cracks" of Medicare eligibility criteria. Although the SGA proposal was not specific, and left room for some confusion, one way of looking at the recommendations is illustrated in Figure 1. For each of the four family status groups (pregnant woman and infants, children aged 1-5, children aged 16-18 and single parent and two parent families) eligibility could be extended, first, to those individuals whose income falls below the state's AFDC payment level, second, whose income falls between the state's AFDC payment level and the state's AFDC need level, and third, individuals whose income falls between the state's AFDC need level and the federal poverty guideline. Extension of coverage to these groups should be optional, but federal financial participation should be provided to states electing to expand eligibility. There should be some restrictions on the states ability to extend coverage, for example, by requiring all mothers and infants to be covered before extending coverage to the other "categorically eligible" groups. This approach could be combined with the gradual phasing-in of a uniform income eligibility criteria, for example, by requiring all states to establish a "payment level" for purposes of Medicaid at a specified percentage of the federal poverty guideline.

Finally, states should be given the option of extending coverage to individuals whose income falls above the federal poverty guideline, but should be encouraged to establish a sliding scale premium for such coverage. This idea was considered in the report of AHA's Special Committee on Care for the Medically Indigent.

I hope these suggestions have been helpful. If I can provide any clarification, please call me at 638-1100.

Sincerely

Jack W. Owen
Executive Vice President

jf

enclosure

FIGURE 1

INCOME LEVEL OF FAMILY	FAMILY STATUS OF INDIVIDUAL			
	PREGNANT WOMEN & INFANTS	CHILDREN AGED 1-5	CHILDREN AGED 6-18	ONE & TWO PARENT FAMILIES
FEDERAL POVERTY LEVEL				
	C	F	I	L
STANDARD OF NEED				
	B	E	H	K
STANDARD OF PAYMENT				
	A	D	G	J
ZERO INCOME				

Various rules could be established to guide the expansion of coverage. For example, before coverage could be extended to groups D through L, groups A through C should be covered. Similarly, before group J could be covered, groups D and G should be covered, and before group I could be covered, groups A through H should be covered. Other sequences could be established, depending on whether the coverage of all children was considered more important than the coverage of all family members in families with extremely limited income.

STATEMENT OF HOWARD N. NEWMAN,
SPECIAL COUNSEL
NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

BEFORE THE
SUBCOMMITTEE ON INTERGOVERNMENTAL RELATIONS
OF THE
COMMITTEE ON GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

June 26, 1986

Mr. Chairman, members of the Subcommittee, I am Howard Newman, Special Counsel of the National Association of Public Hospitals (NAPH). On behalf of the 50 public hospitals and hospital systems around the country which now comprise the membership of NAPH, I appreciate this opportunity to testify today on the subject of access to health care for all Americans. Our member hospitals serve as the health safety net for all uninsured persons in many of our nation's metropolitan areas today.

I would first like to describe the situation of public hospitals generally, and then comment specifically on Senate bill S.2043 - "Access to Health Care Act of 1986."

The Situation of Public Hospitals Today

NAPH has described our nation's public hospital system in considerable detail in previous testimony before this

Committee. However, I believe it is appropriate in the context of this hearing to call your attention again to several key service delivery and financing elements common to America's "safety net" hospitals and direct your attention to a number of new studies which shed further light on the role and situation of public hospitals today.

This nation has repeatedly considered enacting National Health Insurance and it may yet be possible for us to design "solutions" for the problem of uncompensated care that permit all of our nation's citizens access to needed health care. Until that time, however, we must acknowledge that there presently exists a nationwide network of institutions, a mere handful of metropolitan area public and private hospitals, that provide many of the services needed and used today by uninsured individuals. We believe the federal government must take steps to protect and preserve that network. Improving insurance coverage for even small segments of this population, and providing additional financial support for hospital charity care, will help alleviate the increasing burden on large urban public hospitals.

With regard to specific data in support of this general observation, NAPH has conducted and analyzed other new surveys and analyzed new data in the last several months to augment the information we have provided to this Committee in the past. We have conducted an intensive analysis of data collected by other researchers, such as the Urban Institute's survey of 1,700 hospitals, which focused on the extent of medical care for the poor and the financial status of hospitals serving the poor. A summary of the information we have been developing and analyzing is likely to be helpful in understanding the situation of public hospitals today.

° PUBLIC HOSPITALS ARE IMPORTANT PROVIDERS OF PRIMARY AND AMBULATORY CARE TO POOR PERSONS WHO OFTEN HAVE LITTLE OR NO ACCESS TO PRIVATE PHYSICIANS

NAPH members average almost 106,000 bad debt charity care outpatient and emergency room visits, representing about 50% of all visits at these facilities. These uncompensated care visits are a primary reason that public hospitals average 1.5-3 times the number of visits to all hospitals in the nation's 100 largest cities. The costs for this care are high -- almost $11 million per NAPH institution.

Public hospitals also experience a far higher average level of admissions through the emergency room (over 41% for public hospitals in metropolitan areas, as compared with 25-33% for large city hospitals in general).

In addition to the great burden of outpatient/emergency room charity care currently borne by public facilities in our nation's metropolitan areas, the Urban Institute study finds that high volume providers of care to the poor outside the 100 largest cities are reducing emergency room and outpatient hours or staff at a rate approaching twice that of low volume providers, suggesting that metropolitan public hospitals may have to care for these patients as well.

° PUBLIC HOSPITALS IN METROPOLITAN AREAS ALSO PROVIDE SPECIALIZED TERTIARY CARE, PUBLIC HEALTH AND OTHER UNIQUE SERVICES

These services are often too costly or too "unreimbursable" for most private hospitals to maintain. They include burn units -- trauma centers -- emergency alcoholism, drug abuse, and child abuse centers -- neonatal intensive care -- poison control units -- to name just a few. New Urban Institute data shows that public hospitals with operating deficits in the nation's largest cities were nearly four times more likely to have a burn unit, and about twice as likely to have neonatal, pediatric and psychiatric intensive care units than similarly located private hospitals.

° PUBLIC HOSPITALS CONTINUE TO TAKE ALL PATIENTS -- REGARDLESS OF ABILITY TO PAY

Where public hospitals exist, they are "de facto" national health insurance today. According to a 1983 NAPH survey, uncompensated care represented an average of 29% of 1982 inpatient days for NAPH member hospitals (or an average of 46,010 uncompensated inpatient days per hospital). Forty-six percent of all outpatient/emergency room visits to NAPH members, on average, were also uncompensated (106,000 uncompensated care visits per hospital).

° THE NON-MEDICAID UNINSURED CASELOAD OF PUBLIC HOSPITALS HAS SUBSTANTIALLY INCREASED IN RECENT YEARS

The August 1983 NAPH survey of unemployed and uninsured patients in public hospitals demonstrated that these facilities are now the source of health care for thousands of individuals who had relied on other health services before unemployment. Forty-four percent of the unemployed patients surveyed responded that they had not used the public hospitals as a regular source of care before becoming unemployed. Eight hospitals reporting inpatient and outpatient data had a total of 5506 unemployed and uninsured visits or admissions for a seven day period -- an average of 688 per hospital. If this number as projected is annualized, these eight institutions alone would experience over 280,000 visits and inpatient days by uninsured and unemployed patients.

- PUBLIC HOSPITALS HAVE MANAGED THEIR RESOURCES EFFICIENTLY BUT THEIR VERY MISSION OFTEN CAUSES THEM TO OPERATE AT A LOSS

A recent study by Alan Sager indicates that public hospitals have experienced the largest decrease in length of stay, and the only increase in occupancy rate, among all classes of hospitals in the nation's 52 largest cities. Moreover, public hospitals have decreased their total number of beds between 1970 and 1980 -- by over 22% -- in those cities. In addition, most public hospitals are already managed and budgeted prospectively each year, with full, independent review by state and local governmental entities. Finally, such hospitals are often fully integrated institutions with salaried medical staff, and thus do not present many of the potential problems recognized recently by this Committee in separating hospital costs for physician costs.

In summary, caring for the poor in our nation exacts a high price from our public hospitals -- higher costs, lower compensation and a stressed financial condition. And all of these factors are likely to have a severe impact on the ability of public hospitals to attract sufficient capital to enable them to fill this vital role.

Comments on Proposed Legislation

NAPH strongly supports the principles underlying this legislation and we applaud the Chairman for his continued efforts to improve access to health care by improving the financing of hospital care for the uninsured and underinsured. Indeed you can and should consider our member hospitals full partners with you in this effort.

We must emphasize that we believe any ultimate solutions to this problem must necessarily be federal primarily. This population generally fits the mold of what we consider to be a national constituency -- poor, sick, and disabled. We also continue to support a National Health Plan, although we recognize this is currently out of fashion. However, in the not too distant future, we expect to be joined by others in this effort -- for example, by Big Business as their retiree health benefits obligations grow.

NAPH strongly supports the provisions of the bill extending employment-based health insurance coverage for laid-off workers and their dependents, and the creation of subsidized health insurance pools to allow people without employment-based coverage to buy health insurance regardless of their health status. However, the legislation provides for the design and operation of insurance pools to be at the discretion of the States. This flexibility given to the States creates certain problems, such as ERISA preemption, that must be solved if an effective and equitable national program is to be created.

With regard to proposed state systems to fund hospital care for the uninsured, we also support this concept in general, provided that any program give ample recognition to the present reality that there are only a handful of public and private hospitals in most states that presently provide this care.

We are aware of Congress' sensitivity to this as evidenced by the fact that Congress recently passed the Consolidated Omnibus Reconciliation Act of 1986 that provided an adjustment in medicare payments for hospitals serving a disproportionate share if low income patients. We appreciate your efforts Mr. Chairman in obtaining passage of this important legislation.

Under the bill, States must either establish an uncompensated care plan or through an HMO or other mechanism, health care coverage to all residents. Excluded costs for which payment is not provided includes care counted toward a hospital's Hill-Burton obligation, costs "respecting obligations to pay taxes," for "charges that can expect to be collected with suitable bill collection mechanisms," or care provided to Medicare and Medicaid patients. The bill requires the program "to provide for payment for the unreimbursed costs incurred by each hospital in the state in furnishing medically necessary inpatient and outpatient services." The bill gives the state a great deal of flexibility regarding how such costs are to be reimbursed. The only stipulation being that the financing mechanism be "adequate." The enforcement mechanism provided under the legislation would reduce the level of federal financial participation for state Medicaid administrative costs from 50 percent to 25 percent and ultimately to zero.

Our major concern with this legislation is that the method of financing uncompensated care plans should be more clearly delineated. The financing of uncompensated care is a social responsibility. Therefore, the burden of financing care should be shared by hospitals, payers, and all levels of government. Any tax on hospitals could represent a severe hardship on hospitals serving large numbers of Medicare and Medicaid beneficiaries.

The bill lacks precise definition in areas that cause some concern. There is no definition for "adequate" payment levels; there is no standard provided to states to determine exactly what constitutes "unreimbursed costs." NAPH has testified previously that public hospitals providing a high volume of care to the poor have higher costs per inpatient day. This is due primarily to the fact that public hospitals treat more seriously ill patients: - put reference patients with multiple diagnosis and those who are victims of infectious diseases, accidents, violence, and substance abuse. A high proportion of these patients overly utilize emergency rooms. In addition, the bill mandates as a condition of payment under the program to a hospital, that the hospital "(i) provide a certain level of charity and unreimbursed care for inpatient and outpatient hospital services and (ii) meet minimum standards in its efforts to collect unpaid bills." These provisions could have the undesired affect of encouraging hospitals not to participate under the state plan for fear of receiving an inadequate state payment for their "unreimbursed costs" with the requirement for a much higher volume of charity care over and above the hospital's Hill Burton uncompensated care requirement. We believe the language of the bill must be clarified to define adequate "payment levels" and "unreimbursed costs." The amount of payment for uncompensated care under the State plan must provide positive incentives for public hospitals to participate and continue to maintain and increase the amount of uncompensated care provided in the past.

We are also concerned that even as they debate this new legislation, HCFA is moving in the other direction, seeking to prevent States from developing pools or providing additional funds to disproportionate share hospitals.

In conclusion, Mr. Chairman, we would like to commend you for taking the initiative in attempting to improve access to health care services for the uninsured and underinsured and view this legislation as an important first step. We look forward to working closely with you to pass this important initiative. I would be pleased to answer any questions at this time. Thank you.

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July 22, 1986

Honorable David Durenberger
United States Senate
Chairman, Subcommittee on
Intergovernmental Relations
Senate Committee on Governmental Affairs
Washington, D.C. 20510

Dear Senator Durenberger:

This is in response to your June 30 letter, wherein you posed additional questions relating to the Subcommittee's June 26th hearing.

In particular, you asked "what specifically is HCFA doing", as we had testified, "to prevent states from developing pools or providing additional funds to disproportionate share hospitals"? A current example of HCFA's actions that are thwarting states' efforts to provide funds for disproportionate share hospitals is the recent HCFA disallowance of a Georgia State Medicaid Plan amendment that would have provided a 1 percent intensity factor for disproportionate share hospitals.

HCFA informed the Georgia Medicaid program that it disapproved the plan amendment because the proposed intensity payment for disproportionate share hospitals would exceed the "Medicare upper payment limit," which is a regulatory provision (42 CFR §447.253(b)) that appears to be contrary to the plain language of the statutory provisions pertaining to Medicaid reimbursment of hospitals in general, and of disproportionate share hospitals in particular. In 1981, when Congress enacted the Omnibus Budget Reconciliation Act of 1981, (OBRA) it specifically eliminated the statutory reference to a Medicare ceiling on Medicaid reimbursement rates that was part of the pre-OBRA statute. Instead, Congress chose only to limit the rates to the level that is "reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities." §1902(a)(13)(A) of the Social Security Act

("Act"). OBRA also specifically requires state Medicaid plans to "take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs...." §1902(a)(13)(A) of the Act. It was in response to that statutory provision that the Georgia Medicaid program sought to provide for a 1 percent intensity factor for disproportionate share hospitals.

Georgia has appealed the HCFA disallowance, arguing in a May 21st administrative hearing that HCFA erred in refusing to accept Georgia's assurances because the Act and regulations grant considerable discretion to states to (1) develop their own methodologies and standards and (2) make determinations as to the adequacy with which the statutory and regulatory requirements are met. Further, Georgia presented considerable evidence that the adjustment in question did not exceed the Medicare payment limits. In depositions and in testimony offered at the hearing, HCFA officials freely admitted that they had not performed specific calculations to determine if the Georgia disproportionate share hospital adjustment in fact exceeded payment levels under "Medicare principles of reimbursement," but that the one percent intensity factor "appeared" to violate the regulatory ceiling. A decision in this matter has not yet been rendered. However, the case offers graphic evidence of HCFA's actions which undercut, through the implementation of a legally questionable regulatory ceiling, explicit statutory relief for disproportionate share hospitals.

It should also be noted that Georgia is not the only example of HCFA's intransigence regarding disproportionate share hospitals. The New York State Medicaid Plan currently is being questioned by HCFA on substantially the same grounds as Georgia's, *i.e.*, that the Medicaid payments, which take into account the situation of disproportionate share hospitals primarily through a "financially distressed hospital" pool, are in excess of the regulatory Medicare payment ceiling. As of this time, New York apparently is still attempting to convince HCFA that its payment rates do not exceed the Medicare ceiling.

These examples demonstrate that HCFA is violating the spirit and probably the letter of the Social Security Act insofar as Congress explicitly evidenced an intent that the special needs of disproportionate share hospitals should be recognized in the development of prospective and other innovative reimbursement systems. Congress could remedy this situation by amending the Social Security Act to (1) nullify the regulation that establishes a Medicare payment ceiling on Medicaid payment rates, or (2) exempt reimbursement provisions designed to assist disproportionate share hospitals from such ceilings. We would be pleased to elaborate on either alternative.

You also sought our suggestions regarding Congressional action to "ensure that disproportionate share hospitals receive the additional Medicare reimbursement" intended by COBRA. Enclosed are NAPH's comments on the proposed regulations implementing the relevant COBRA provisions, published in the Federal Register on May 6, 1986. Briefly, our comments focused on the proposal's lack of clarity with respect to applications by disproportionate share hospitals for relief under COBRA's provisions. We also strongly opposed the regulatory provisions that would exclude from the calculation of indigent care those funds furnished to the hospital to cover general operating deficits. We believe that this provision is contrary to Congressional intent in enacting §9105 of COBRA, and should be removed from the final regulations.

I trust that this information is useful to you and responsive to your questions. If you desire further information or comments on any of the issues addressed herein, please contact me.

Sincerely,

Howard N. Newman

HNN:rm

Enclosure

Memorandum to Senate Finance Committee

From Larry S. Gage

Re: Possible need for disproportionate share hospital
technical amendment

As you recall, Sec. 9105 of COBRA provided that an urban hospital with more than 100 beds could qualify for the maximum disproportionate share hospital adjustment if it could demonstrate that "its net inpatient [non-Medicaid] revenues . . . for indigent care from State and local government sources exceed 30% of its total of such revenues . . ." (Attachment A)

I've underscored the words "for indigent care" because they are essential to the purpose of this provision, and they may require clarification in light of HCFA's proposed interpretation.

In particular, while HCFA's actual regulation merely repeats the statutory requirement, the May 6 preamble to that regulation sought to "clarify" this phrase by indicating that it would be "incumbent upon a hospital to demonstrate . . . that these revenues are specifically earmarked for the care of indigents (that is, none of that money may be used for any purposes other than indigent care)."

HCFA's preamble then goes on to state that "among the types of care that are not to be included by the hospital as indigent care" are "funds furnished to the hospital to cover general operating deficits." (Attachment B)

The problem is, not all public hospitals "specifically earmark" their direct appropriations in the manner presupposed by these instructions. State and local budget processes differ markedly from one another, and it is entirely possible that two otherwise-identical public hospitals with 50% direct local subsidies and 50% uninsured indigent patients would be treated differently for purely semantic reasons if the HCFA constraints are literally enforced.

In other words, while some cities, counties or states may actually earmark subsidies specifically for patient care, others account for such funding differently -- including "to cover general operating deficits", as HCFA puts it. What is important in such instances is to permit such hospitals sufficient flexibility to demonstrate that these "operating deficits" are in fact caused by the provision of inpatient indigent care, within the clear meaning of the statute. To avoid endless wrangling (and perhaps litigation) over this issue, a technical clarifying amendment appears to be desireable. I would be happy to suggest appropriate language if you wish.

At the present time, we believe about a dozen NAPH member hospitals may possibly need this clarification. (That is, they will need the "30% of revenues" exception to qualify for an adjustment at all, or for the maximum of 15%.) We will gather more specific information this week, but preliminarily, the following hospitals may be affected:

Harris County Hospital District, Houston
Wishard Memorial Hospital, Indianapolis
Denver General Hospital
University of Texas, Galveston
University of Texas, Tyler
R.E. Thomason Hospital, El Paso
Jackson Memorial Hospital, Miami
Harold D. Chope Memorial Hospital, San Mateo, Ca.
Charity Hospitals of Louisiana (several in system)
Dallas County Hospital District
Amarillo Hospital District

I will also provide you with a list setting out the impact of the "formula" based adjustment on other public hospitals (we should have a complete list by in the next several days).

With regard to efficient implementation of the formula-based disproportionate share adjustment around the country, it seems to depend on the relative efficiency of a hospital's fiscal intermediary. Some of our members have already been notified of their adjustment and payments have begun to flow. Others have heard little or nothing from their FI. We are following this.

I look forward to talking with you soon about this concern.

June 6, 1986

MEMORANDUM

TO: Health Care Financing Administration
Department of Health and Human Services
Room 309-G
200 Independence Avenue, S.W.
Washington, D.C.

From: Larry S. Gage, President
National Association of Public Hospitals

Re: File: BERC-285-IFC. NAPH Comments on Interim Final Rule Implementing Certain Sections of the Consolidated Omnibus Budget Reconciliation Act of 1985

The purpose of this submission is to provide HCFA with comments on various provisions of interim final regulations published in the Federal Register on May 6, 1986 which implement the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). These comments are provided on behalf of the National Association of Public Hospitals (NAPH) whose membership includes seventy public hospital systems in metropolitan areas across the country.

The focus of these comments are the proposed adjustments in Medicare payments for hospitals that serve a disproportionate share of low income patients, as required by Section 9105 of COBRA. This provision is the latest step in a process that began in 1982 with the enactment of the Tax Equity and Fiscal Responsibility Act, wherein Congress recognized the need for special adjustments in Medicare reimbursement for "disproportionate share" hospitals.[1] The seriousness of

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[1] Previously, Congress had required state Medicaid programs to take into account the circumstances of

Congress' interest in this issue has been illustrated by its subsequent annual direction to HCFA to provide some sort of adjustment or accommodation for such hospitals, so that the rigid payment mechanisms of TEFRA and the prospective payment system do not place undue burdens on hospitals that must incur increased costs for special services for indigent patient populations. This ongoing concern resulted, finally, in the enactment of Section 9105, which specifically provides for two methodologies by which hospitals may obtain adjustments of up to 15% in the national portion of their prospective payment rates. These two methodologies require: (1) a calculation of the percentage of elderly and non-elderly low-income inpatient days exceeding a 15% threshold (Formula Option), or (2) a calculation of the net inpatient revenues from state and local government sources devoted to indigent care exceeding 30% of all net revenues (Revenue Option).

Although HCFA had been reluctant to provide relief to disproportionate share hospitals in the past, stating on numerous occasions that the need for such adjustments was not proven, the adoption of this explicit provision clearly indicates that the Congress has found that disproportionate share hospitals have higher Medicare costs that must be recognized. This finding is therefore no longer in question, and we therefore expect that the regulations implementing Section 9105 of COBRA will accurately reflect the letter and intent of this provision.

In that regard, we are pleased to note that the regulations do mirror in many respects the explicit requirements of Section 9105. However, there remain several important problems and issues raised in these regulations, which we strongly urge you to correct and which we will discuss below.

I. Application for Relief Under Section 9105

The regulations contain little guidance as to how an application for relief under Section 9105 should be presented, and how such an application will be considered by the intermediaries and HCFA. There is merely a brief discussion in the preamble about the fiscal intermediary's role in determining the number of patient days of patients entitled to Medicaid, and related issues regarding a hospital's eligibility for the disproportionate share adjustment. Neither the preamble nor the regulations address the means by which the adjustment may be sought be a hospital, the time requirements for such application, the relative roles between HCFA and the fiscal

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hospitals that serve a disproportionate number of low income patients with special needs. Omnibus Budget Reconciliation Act of 1981.

intermediaries regarding the consideration of such an application, and the criteria by which such applications ultimately will be judged.

Further, there is no description of an appeals process available to hospitals that are denied a disproportionate share adjustment. In light of the prior resistance to this adjustment, a fair and workable appeals process takes on a greater importance. We believe that these regulations must contain a clearly identified appeals procedure to ensure that the actual reimbursement relief envisioned by Congress can become a reality, and not be thwarted by unresolved disputes involving accounting differences.

II. Calculation of Thirty Percent Threshold - Use of General Operating Deficits

The regulations provide that "funds furnished to the hospital to cover general operating deficits" are "not to be included by the hospital as indigent care" for the purposes of calculating whether more than 30% of a hospital's total inpatient care revenues are from state and local government sources (such funds must be specifically earmarked for the care of indigents).

This provision is illogical and counter to the purpose of the Revenue Option provided by Congress. This alternative adjustment was inserted by Congress to ensure that disproportionate share hospitals that do not meet the criteria of the first alternative methodology (Formula Option) do not "fall through the cracks" and thus be denied reimbursement relief. In attempting to drastically limit the availability of the Revenue Option, HCFA does not appear to be aware of how state and local governments provide support for many disproportionate share hospitals. A basic objective of subsidies from governmental entities is to enhance the ability of the hospitals to provide care for indigient patient populations. Whether the subsidy is termed "patient care revenues" or "operating subsidies" is immaterial - the literal categorization of the subsidy depends totally on the established state and local reporting and financial support mechanisms. Other than the fact that the funds are intended to support care for the indigent, the method of labeling and accounting has little to do with the "disproportionate" status of any recipient hospital. In fact, the actual use of the subsidy was intended by Congress to be the precise issue. The proposed regulation is clearly incorrect in this regard, and as currently written would penalize hospitals simply because they are conforming to accounting methods required by their state or local governments.

Further, Congress has accepted the plain fact that the care and treatment of a significant number of low income patients will result in significant additional costs. NAPH has previously provided Congress and HCFA with a general description of the special needs that are met by disproportionate share hospitals, i.e.:

- to provide unreimbursed health services to uninsured indigent patients;
- to provide services to patients who speak little or no English;
- to maintain a sizeable staff to make eligibility and other administrative determinations for patients for Medicaid and other programs;
- to provide social services in addition to health care services for patients, including the fulfillment of basic needs such as housing and nutrition;
- to provide additional outpatient and emergency services for patients who often have no access to primary care in any other form;
- to provide extra services associated with particular (and often unreimbursable) health problems more prevalent among indigent patients, such as alcoholism, drug abuse, or care of persons who have been denied necessary care in earlier stages of their lives or spells of illness (including the costs of extra diagnostic tests for such patients);
- to provide services for chronically ill or other patients in need of long term care, but for whom (because they are poor) substantially fewer SNF and ICF beds are available;
- to provide non-emergency transportation services to low income patients with no other means of transportation;
- to serve particular low income populations, such as refugees or undocumented aliens, who are often considered outside even the non-Medicaid populations for which some State or local governments will provide some reimbursement;
- to maintain extra staff to provide patient education systems geared to the special needs of the poor, to encourage self care and other preventive health activities, as well as to attempt to better control the future of expensive hospital-based services when lower levels of care are more appropriate;

- to maintain and provide certain highly specialized tertiary care services, such as shock-trauma units, burn centers, poison control, neo-natal care, units specializing in teenage pregnancy problems, etc., which are needed by the community but are not generally cost-effective for private institutions;
- to maintain special institutional programs in areas such as nutrition, dental care, child and spousal abuse, rape crisis, etc., both for the general community and for low income patients who have a need for but would otherwise have no access to such services;
- to maintain the necessary capacity (including extra staff) to work closely with criminal justice system;
- to maintain "discharge planning" units to deal with the social disposition problems of patients ready for discharge, but who may have no home, family or job, or who may have other (not necessarily health-related) social needs; and
- finally, for the nation as a whole, to continue to serve wherever possible as a form of "national health insurance" by default, as the country's health care "safety net," so that for the time being, at least, the wealthiest and most powerful nation in history will be able to continue in most parts of the country to provide a decent level of health care for those among its citizens who are least able to care for themselves.

Congress has recognized that the services listed above result in additional costs and often in operating deficits. In light of Congress' indisputable effort to provide additional reimbursement to meet those costs, the provision excluding funds used to cover general operating deficits makes no sense. Clearly, these are the very sort of added costs that Congress sought to counter with exceptions, adjustments, or additional reimbursement provisions for disproportionate share hospitals. There is no legitimate policy or legal justification for excluding funds used to meet general operating deficits, and we strongly urge the withdrawal of this provision from the regulations.

III. Calculation of Adjustments for Revenue Option and Formula Option

As previously noted, the regulations provide hospitals with two alternative means of achieving an adjustment in their prospective payment rates due to their disproportionate share status. While we recognize that the statute requires HCFA to make these adjustments retroactive to May 1, 1986, it is apparent that the calculation of the alternative methodologies cannot be performed simultaneously. The proposed regulations provide that the fiscal intermediaries will determine if hospitals qualify for the Formula Option. As discussed above, the regulations do not address the process of qualifying for the Revenue Option. Thus, it is likely that qualification under the Revenue Option will be delayed to some extent, or at least will be undertaken after any qualification under the Formula Option.

We are concerned that a hospital that may qualify under both options may be "locked in" by HCFA to the first Formula Option, even though that hospital may be entitled to a larger adjustment under the Revenue Option. To avoid this inequity, which would result simply by the differences in timing of the determinations of qualification for the two options, we recommend that a hospital's qualification under the Formula Option should not prevent that hospital from choosing subsequently the Revenue Option if that alternative would provide for a higher reimbursement adjustment. Further, we believe that payments under the Formula Option should not be delayed if a hospital subsequently elects to apply for the Revenue Option.

IV. Hospital Financial Responsibility

The regulations provide that under the Formula Option, hospitals may choose to determine their number of patient days of those patients entitled to Medicare Part A and SSI benefits based on the hospital's own cost-reporting periods, provided that the full cost of this process is borne by the hospital. We see no justification for this requirement. The purpose behind these regulations is to provide financial assistance to disproportionate share hospitals. Placing what may be a considerable price tag on the use of this process appears to be a departure from the plain meaning of Section 9105, and of Congress' intent. We urge the withdrawal of this provision.

We appreciate the opportunity to provide you with these views. For further information, please contact Larry S. Gage, President of the National Association of Public Hospitals, at 1110 Vermont Avenue, N.W., Suite 105C, Washington, D.C. 20005, telephone number 347-0066.

DISPROPORTIONATE SHARE ADJUSTMENT FIGURES

HOSPITAL	$\frac{\text{SSI}}{\text{MEDICARE}}$	$\frac{\text{MEDICAID DAYS}}{\text{TOTAL PATIENT DAYS}}$	TOTAL	HOSPITAL DISPROPORTIONATE SHARE ADJUSTMENT (BY FORMULA)	QUALIFY FOR STATE AND LOCAL REVENUE EXCEPTION (YES/NO)
AMARILLO	10.52%	3.90%	14.42%	no	
BRACKENRIDGE	14.27%	N/A			
CHARITY HOSPITAL	28.64%	14.00%	42.64%	yes: 15%	
CHOPE	20.31%	9.70%	30.01%	yes: 10%	
CONTRA COSTA	19.26%	21.42%	40.65%	yes: 15%	
COOK COUNTY	15.79%	25.50%	41.29%	yes: 15%	
CLEVELAND METRO	12.25%	26.40%	38.65%	yes: 14.3%	
DENVER	16.96%	N/A			
BOSTON CITY	18.60%	25.90%	44.50%	yes: 15%	
EARL K. LONG	29.42%	N/A			
DC GENERAL	23.73%	25.80%	49.53%	yes: 15%	
FRESNO VALLEY	15.51%	46.00%	61.51%	yes: 15%	
GENERAL, VENTURA	18.20%	35.90%	53.10%	yes: 15%	
GRADY MEMORIAL	28.06%	36.57%	64.63%	yes: 15%	

HARBOR UCLA	23.86%	41.90%	65.76%	yes: 15%
HARBORVIEW	21.41%	49.00%	70.41%	yes: 15%
HIGHLAND GENERAL	N/A	N/A		
HURLEY	10.81%	21.40%	32.21%	yes: 11%
JACKSON MEMORIAL	17.57%	18.40%	35.97%	yes: 13%
HARRIS COUNTY	22.75%	7.20%	29.95%	yes: 10%
KERN COUNTY	32.11%	47.30	69.41%	yes: 15%
LA/KING/DREW	30.81%	45.20%	76.01%	yes: 15%
LA/USC	27.67%	47.50%	75.17%	yes: 15%
MARICOPA	30.60%	39.00%	69.60%	yes: 15%
MEMORIAL	18.50%	13.94%	32.44%	yes: 11.2%
MILWAUKEE	12.56%	19.00%	31.56%	yes: 10.8%
NASSAU	6.94%	23.64%	30.58%	yes: 10.3%
PACIFIC	8.53%	7.10%	15.63%	yes: 2.8%
PARKLAND	22.08%	11.00%	33.08%	yes: 11.5%
PONTIAC	5.66%	N/A		
QUINCY	4.82%	N/A		
REGIONAL MEDICAL	39.42%	26.00%	65.42%	yes: 15%

R.E. THOMASON	18.60%	9.50%	28.10%	yes: 9%
RIVERSIDE	22.81%	45.10%	67.91%	yes: 15%
SAN BERNADINO	18.94%	33.00%	51.94%	yes: 15%
SAN FRANCISCO	20.68%	25.30%	45.98%	yes: 15%
SAN JOAQUIN	27.04%	45.70%	72.74%	yes: 15%
SANTA CLARA	22.59%	52.40%	74.99%	yes: 15%
SPARTANBURG	13.02%	3.70%	16.72%	yes: 3.4%
ST. LOUIS	24.14%	20.08%	44.20%	yes: 15%
ST PAUL-RAMSEY	11.54%	14.42%	25.96%	yes: 8%
TRUMAN	20.62%	22.60%	55.62%	yes: 15%
UNIVERSITY OF CINN	.90%	32.20%	33.10%	yes: 11.5%
UMDNJ	23.12%	N/A		
UNIVERSITY OF N.M.	15.20%	15.00%	30.20%	yes: 10.1%
UNIVERSITY OF OREGON	13.71%	10.00%	23.71%	yes: 6.9%
UNIV OF TX, GALVESTON	15.63%	3.60%	19.23%	yes: 4.6%
UNIV OF TX, TYLER	9.92%	3.70%	13.62%	no
WESTCHESTER	8.78%	34.00%	42.78%	yes: 15%
WISHARD	3.93%	18.00%	21.93%	yes: 6%

NYCHHC:

BELLEVUE	21.03%	32.60%	53.63%	yes: 15%
BRONX	15.20%	40.10%	55.30%	yes: 15%
ELMHURST	10.70%	21.50%	32.20%	yes: 11.1%
CONEY ISLAND	10.20%	35.10%	45.30%	yes: 15%
HARLEM	24.70%	32.40%	79.60%	yes: 15%
KINGS COUNTY	21.80%	51.20%	76.50%	yes: 15%
LINCOLN	28.70%	74.30%	87.10%	yes: 15%
METROPOLITAN	26.20%	42.50%	76.00%	yes: 15%
NORTH/CENTRAL	15.40%	58.80%	62.80%	yes: 15%
QUEENS	15.86%	27.20%	43.60%	yes: 15%
WOODHALL	N/A	55.00%		

Prepared Statement of Sister Dolores Super

Good morning, Mr. Chairman and Members of the Subcommittee.

I am Sister Dolores Super, a Benedictine nun, presently serving as the Chairperson of the Board of Trustees of St. Cloud Hospital, a 522 bed hospital in St. Cloud, Minnesota. I am also Academic Dean at the College of St. Benedict in St. Joseph, Minnesota.

Senator Durenberger, on behalf of the Catholic Health Association of the United States (CHA) whose membership includes over 900 hospitals and long-term care facilities nationwide, I am grateful to have this opportunity to appear before you this morning in support of your bill, The Access to Health Care Act of 1986 (S. 2403). It greatly encourages me, and is a source of hometown pride, to have you take a leadership role in addressing the alarming, and growing incidence of medical indigence in the United States. Our country correctly believes that it has the premier health care delivery system in the world. Nevertheless, the fact that millions of Americans still do not have access to adequate or necessary health care raises fundamental questions about the system's integrity from the point of view of justice.

As you know, Mr. Chairman, several factors explain why ensuring the availability of health care services for the poor has become such an urgent concern. A marketplace environment, driven by competition among health care providers, requires that persons pay for the services they need. In such an environment there are few, if any, economic incentives to provide care for those unable to pay. Because many poor persons lack either public or private health insurance, and many more are under-insured, their access to health care services is seriously diminished. The problem is further exacerbated by employers' and insurers' understandable efforts to bring their own health insurance costs under control by reducing payments to providers, thus limiting dollars previously available for the care of the poor. Lastly, unprecedented federal deficits and disproportionate budget cuts in health care reimbursement have aggravated the overall problem by seriously impacting such programs as Medicare and Medicaid.

Thus, the current preoccupation with controlling health care costs, to the neglect of the other equally important goals of improved access and quality, is causing our nation to renege on its long-standing commitments to provide for the health care needs of the less fortunate in our society. This is a commitment premised in justice, not charity. In short, the health care poor are one of the principal casualties in our nation's current deficit reduction battle.

In April, the Board of Trustees of the Catholic Health Association adopted a report of a CHA Task Force on Health Care of the Poor entitled: NO ROOM IN THE MARKETPLACE: THE HEALTH CARE OF THE POOR. Over a year in making, this report contains a series of recommendations aimed at challenging Catholic health care facilities, the Catholic Church in the United States and federal and state governments to better ensure health care services for the poor and those without health insurance or sufficient health insurance. We have provided you and each member of the subcommittee with a copy of the Report and have submitted a copy for inclusion in the record of these proceedings.

Mr. Chairman, CHA continues to believe that universal health insurance remains the superior method of insuring access to health care for all. However, until that ideal becomes politically achievable, CHA strongly supports interim legislative initiatives, such as your bill, S. 2403, and its companion bills, S. 2402 sponsored by Senator Kennedy and H.R. 4742 sponsored by Congressmen Stark and Gradison, that will improve the poor's access to health care. In particular, four of the five key elements of your bill are similar to recommendations proposed in the CHA Task Force on Health Care of the Poor:

- Both seek an extension of employment-based health insurance coverage for laid-off workers and their dependents.
- Both seek the establishment of subsidized state health insurance pools to allow persons without access to employment-based coverage to buy individual health insurance regardless of their health status.
- Both would require states to establish a mechanism to fund hospital charity and unreimbursed care.
- Both would change the tax laws to encourage more employers to provide health insurance to their employees and employees' dependents.

Encouraged by your initiative and challenged by the recommendations issued by the CHA report to our own institutions, the Catholic Health Association is desirous of working with you and other like-minded groups and associations to ameliorate the problems facing our nation's health care poor. S. 2403 is an important and necessary step in that direction. So, too, I want to add parenthetically, is the Chairman's sponsorship of S. 1620 which would create a National Council on Access to Health Care. The Council would further examine problems relating to the quality and accessibility of health care services in the United States.

On behalf of CHA, Mr. Chairman, I thank you for your leadership on both of these initatives. I would be happy to answer any questions you might have.

The Catholic Health Association
OF THE UNITED STATES
CHA

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July 21, 1986

The Honorable David Durenberger
154 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Durenberger:

Pursuant to your June 30 correspondence to Sister Dolores Super, OSB, who testified on behalf of the Catholic Health Association of the United States (CHA) in support of your bill, S. 2403, the Access to Health Care Act of 1986, I am taking the liberty of responding to questions you raised with Sister Dolores regarding another very important and parallel legislative proposal that would initiate a broad national discussion with respect to the access and quality of the nation's health care services.

On September 10, 1985, Senator Paul Simon of Illinois and Representatives Richard Gephardt of Missouri and Henson Moore of Louisiana joined you in introducing a proposed amendment (S. 1620/HR 3253) to Title XVIII of the Social Security Act establishing a National Council on Access to Health Care. The proposal is presently awaiting markup in the Senate Governmental Affairs Committee and has been referred jointly in the House of Representatives to the Ways and Means and Energy and Commerce Committees.

S. 1620/HR 3253, which CHA strongly supports, would create a 15-member, bipartisan national council to explore the nation's health policy in general, with particular emphasis on ensuring continued or improved access to quality health care services. It would be composed of prominent experts in all fields related to health care, i.e., law, business, labor, medical ethics, social sciences, insurance, physicians, health care administrators, the elderly and other health care consumers.

The congressionally-mandated council would probe such areas as demographic, economic, societal, cultural and aging trends in America and the effects of these trends on the nation's health care needs. In addition, it would examine the differences in the quality and availability of health care services for various economic and geographic segments of the population; the efficient and effective use of existing health care resources; capital and operating costs of health care services; and the integration of alternative health care services with acute and long-term care facilities and services.

Representing over 900 hospitals and long-term care facilities nationwide

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With assistance from existing health agencies, the council would do research and conduct local conferences and regional public hearings to acquire as broad a perspective as possible with regard to health care problems and needs in the United States and the proper role of government and others in the financing, delivering, supervising and planning of health care services. The council would report its findings annually and make recommendations to the President and Congress at the end of its three-year study.

The Catholic Health Association has recently testified in Congress on three legislative initiatives that address the alarming and growing incidence of medical indigence in our nation. Your bill, S 2403, the Access to Health Care Act of 1986 (and its companion bills S 2402 sponsored by Senator Edward Kennedy of Massachusetts, and HR 4742 sponsored by Representatives Fortney "Pete" Stark of California and Willis Gradison of Ohio) is an important and necessary step toward ameliorating a problem facing more than 37 million health care poor Americans. We have pledged to work for its enactment.

However, CHA is likewise convinced that a larger, more coordinated evaluation of the entire health care system is essential to arrive at long-term solutions to our broad-based health care problems. We believe that all of us share responsibility for the crisis in health care which confronts and challenges us and that we all must work together to solve it. Our nation must stop relying on short-sighted, stop-gap measures to control health care costs without solving the basic problems that escalate these costs.

Health care is a basic human right. The formation of a national council may be the best way to guarantee that all of us will be able to continue exercising that right in the years to come. At the very least, CHA believes that the enactment of the National Council on Access to Health Care Act of 1986 (S 1620/HR 3253) would raise and encourage a level of public debate about health care in America that would not otherwise occur. In turn, such a debate could prompt not only an analysis of possible approaches to the health care crisis, but more importantly, the development of a variety of positive proposals for dealing with the complexities of health policy in general.

I would like to point out that CHA's role in advocating for the establishment of a national council is in keeping with a series of other efforts we have made recently to bring the health care debate into proper focus. These efforts have included a national advertising campaign in NEWSWEEK, THE WALL STREET JOURNAL and other leading publications; production of an educational videotape entitled, HEALTH CARE IN AMERICA; a special advertising supplement in the June 30, 1986 issue of FORBES, carrying interviews with you and the other three congressional sponsors of S 1620/HR 3253; the formation last year of a Task Force on Health Care of the Poor, which recently concluded its work and published its findings in a report entitled, NO ROOM IN THE MARKETPLACE: HEALTH CARE OF THE POOR; and another soon-to-be appointed CHA task force on health care of the elderly.

In conclusion, the Catholic Health Association considers the intent of your Access to Health Care bill, S 2403, to be completely compatible and complementary to the comprehensive overview of health care needs envisioned by the creation of the National Council on Access to Health Care. Focusing the public spotlight on the issue of accessibility to health care services, as S 2403 does, only serves to emphasize the absolute need to begin a national discussion of the long-term goals, priorities and health care problems facing our nation. Providing a forum for such a debate, as S 1620 would, can only strengthen our health care delivery system and make it one that serves all Americans in the best way possible.

Thank you for your continuing interest in these issues and your leadership and sponsorship of S 2403 and S 1620.

With best wishes,

Sincerely,

William J. Cox

William J. Cox
Vice President
Government Services

cc: Sister Dolores Super, OSB
Jack E. Bresch, CHA Congressional Liaison

Prepared Statement of Gail Litfin

Mr. Chairman and members of the Subcommittee, my name is Gail Litfin. I am 28 years old and have had diabetes since I was 9. I am here today because I am unable to obtain health insurance. I am representing the American Diabetes Association and the Coalition on Health Insurance Availability, a Coalition comprised of forty-one national organizations seeking legislation to help people with chronic health conditions -- like diabetes -- with developmental disabilities, and physical or mental impairments who currently are unable to obtain health insurance. The Coalition's statement is attached to my own.

The American Diabetes Association, the Coalition on Health Insurance Availability and I, personally, wish to express our strong support for the provision on pooled risk health insurance contained in the "Access to Health Care Act of 1986."

In addition to my diabetes, I suffer from numerous complications. I am blind in one eye and see very little with the other. I have no real night vision. I have had problems with tissue inflamation in my legs for which I have had to be hospitalized. And I will need a kidney transplant in the near future. Right now, this is my major concern. It seems like I would have to have total kidney failure before I could get any help.

When I was growing up my father worked for the Social Security Administration. His salary started at about $9,000 dollars a year and rose to about $30,000 dollars a year. My mother did not work because she had five children, and three of us had diabetes. My sister, Natalie, and my brother, Mark, were both diagnosed at age 7. We were all covered by my father's Blue Cross/Blue Shield health insurance policy, which he had through his work. This policy was good for emergencies but did not pay for routine doctors visits, syringes, insulin or the supplies needed to perform urinanalysis. We could only afford to go to the doctor to have our blood sugar tested once a year. Blue Cross/Blue Shield would have paid for part of these visits but we could not afford the $100 deductible for each kid.

My sister with diabetes is now married to a man in the Coast Guard and is covered under his insurance policy. My brother, Mark, is dead. He died 10 days before his 21st birthday from giving himself too much insulin. Before he died he was in a coma for 5 weeks. It was almost a relief when he died because on his 21st birthday he would no longer have been eligible under my father's insurance plan, and we didn't know what we were going to do since he would have needed continued hospitalization or nursing home care.

In 1980, I completed my bachelor's degree in media/communications at the University of Maryland. During college I worked at the Goddard Space Flight Center. I worked for the Baltimore Civic Center from June 1979 to November 1980. Following graduation I worked for three years at the Baltimore Community Relations Commission as an investigator for equal employment opportunity complaints. When I worked for the city I had Blue Cross/Blue Shield health insurance but, like before, it did not cover routine care or pay for the supplies and insulin that I needed. I believe that many of the problems I have had and those of my brother and sister could have been avoided if we had had better insurance coverage.

In 1983 literature was passed around at work saying we could change our health insurance coverage and join an HMO (health maintenance organization) called Carefirst. It sounded like we would have more coverage and routine, preventive care would be available. So I joined the HMO only to find out that their doctors did not know about diabetes and visits to specialists would not be paid for.

Under Blue Cross/Blue Shield I was able to get a home blood glucose monitor so that I could control my diabetes better. I also felt I needed an insulin pump but Carefirst would not pay for the pump because their doctors did not recommend it. My Carefirst doctor told me, "You really know what you are talking about," but would not put a recommendation in writing. I think this was because he was not very familiar with the pumps and he didn't want to recommend a device that cost very much.

I went ahead and put my own money down on a pump and got it. Months later Carefirst did pay for it, but I had to go to the Civil Service Commission, write the Carefirst grievance committee several times and appear at a hearing. They did not change their policy but made an exception for me because I didn't give up.

In 1984 I was laid off. This had nothing to do with my diabetes. I was able to convert my coverage under Carefirst to an individual policy but could not keep up the $120 monthly premium since I had no income.

Soon after my eyes got worse and I was declared legally blind. I applied for and got Social Security Disability Insurance (SSDI) benefits. I am now getting $551.00 a month in SSDI benefits but am still waiting for the 2 year waiting period to be over so I can get Medicare coverage. The $551.00 is not enough to pay for my health care needs in addition to my living expenses. My monthly budget should be:

$230.00	rent
50.00	phone and utilities
50.00	blood testing strips
75.00	plastic tubing for my pump
15.00	insulin
200.00	food, transportation and all other expenses
$620.00	TOTAL

However, I cut corners. Instead of changing the plastic tubing in my pump every day, like I'm supposed to, I make the tubing last up to 6 days. Also, I only test my blood twice a day most days, instead of 3-4 times like I should.

It is not an easy life. I continue to collect medical bills and be threaten by collectors. I try and carry on a normal life but this whole insurance thing drains me. I found out that to be eligible for the Maryland Medical Assistance program I must incur additional medical expenses exceeding $1,370 dollars. I have met this criteria but some of my bills are "too old" and therefore do not count.

I realize that the pooled risk health insurance programs have high premiums that I currently could not afford. However, I am attending classes to complete my master's degree and believe that my right eye will improve with time. I expect to go back to work and be able to pay for my own health insurance if need be. I would like to free lance and know that I could not go back to the HMO or obtain other insurance with all my pre-existing conditions. A pooled risk insurance program would be the answer for me and many others like me. I urge the Committee to pass this legislation as soon as possible.

I also would like to recommend that there be some consideration of a premium based on a sliding scale so that persons with little or no income also can have an opportunity to obtain health insurance.

Thank you for asking me to testify today.

Coalition for Health Insurance Availability

Statement in Support of the
Health Insurance Risk Pooling Provisions
of the
Improved Access to Health Care Inititive
June 9, 1986

The Coalition for Health Insurance Availability, comprised of 41 national organizations representing individuals with chronic health conditions or disabilities and older Americans, supports the provision of the "Access to Health Care Act" that will provide access to health insurance to individuals and families who are willing but unable to purchase it. This legislation (H.R. 4742 and S. 2402/S. 2403) was introduced on May 1 by Congressmen Stark and Gradison in the House of Representatives and by Senators Kennedy, Durenberger, Heinz and Riegle in the United States Senate.

Many of those unable to obtain insurance coverage are people with developmental disabilities, physical or mental impairments, and chronic health conditions. In many cases these are working people who are willing and able to pay for health insurance but are unable to purchase it because each has a pre-existing condition. In other cases they are older people who, upon leaving their employment, find they cannot purchase individual coverage. At the time they need health insurance most, they are left without it. The inability to obtain adequate insurance has serious consequences not only for these individuals but for their families as well.

The Stark-Kennedy bills would encourage states to establish risk pools to make reasonably priced insurance available to those who cannot purchase it on the open market.

Several models for an effective risk pool already exist. Nine states already have some form of risk pool offering comprehensive major medical insurance to people considered by insurers as "high risks." These states are Connecticut, Florida, Indiana, Minnesota, Montana, Nebraska, North Dakota, Rhode Island, and Wisconsin. Purchasers pay into the pool like any other group health coverage. If the pool experiences losses, those losses are proportionately shared by all the insurers conducting business in the state.

The Stark-Kennedy bill will not require the expenditure of any federal funds. This legislation simply establishes minimum standards based on the experiences of successful state pools. Each pool would be established and regulated in each state similar to other state insurance programs.

Millions of people who, because of health problems, are unable to purchase health insurance in any other fashion, would be afforded coverage. That is why we support the enactment of risk pooling legislation. The Health Insurance Association of America representing the commercial health insurance companies also supports the risk pooling provision contained in the Stark-Kennedy bills.

The denial of health insurance frequently means the denial of health care. It is critical that risk pooling legislation be enacted this year.

COALITION FOR HEALTH INSURANCE AVAILABILITY

ACLD, Inc. An Association for Children and Adults with Learning Disabilities
Alliance for the Neurologically Impaired
American Association of Retired Persons
American College of Gastroenterology
American Diabetes Association
American Foundation for the Blind
American Liver Foundation
American Medical Student Association
American Speech-Language-Hearing Association
Amyotrophic Lateral Sclerosis Association
Arthritis Foundation
Association for Retarded Citizens
Cooley's Anemia Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation of America
Handicapped Organized Women, Inc.
Health Insurance Association of America
Huntington's Disease Foundation of America
Immune Deficiency Foundation
Lupus Foundation of America
MPS (Mucopolysaccharidoses) Research Funding Center, Inc.
National Association of Children's Hospitals and Related Institutions, Inc.
National Association of Developmental Disabilities Councils
National Coalition for Rare Disorders
National Consumers League
National Easter Seal Society
National Head Injury Foundation
National Foundation for Illeitis and Colitis
National Huntington's Disease Association
National Mental Health Association
National Multiple Sclerosis Society
National Rehabilitation Association
National Society for Children and Adults with Autism
National Sudden Infant Death Syndrome Foundation
National Women's Health Network
Sickle Cell Support Association
Sick People Need Insurance (SPINS)
Sick Kids Need Involved People (SKIP)
Spina Bifida Association of America
Tourette Syndrome Association, Inc.
United Cerebral Palsy Associations, Inc.

For Further Information:

Myrl Weinberg (703-549-1500) OR Richard Nugent (301-459-3700)
American Diabetes Association   Epilepsy Foundation of America

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Victoria Jaycox
Executive Director

STATEMENT OF THE OLDER WOMEN'S LEAGUE

on

ACCESS TO PRIVATE HEALTH INSURANCE

presented to the

SUBCOMMITTEE ON INTERGOVERNMENTAL RELATIONS

of the

SENATE GOVERNMENTAL AFFAIRS COMMITTEE

June 26, 1986

Senator Durenberger, members of the Subcommittee. Good morning. I am Lou Glasse, President of the Older Women's League. OWL is the first national membership organization to focus on the concerns of midlife and older women.

Founded in 1980, OWL has 20,000 members and chartered chapters in 35 states. Through education, research and advocacy, we work for public policy changes to reduce the inequities women face as they age. Among their greatest concerns is access to affordable health care.

The Older Women's League appreciates this opportunity to share those concerns with the Subcommittee. We commend you for focusing on the lack of either private or public health coverage among millions of Americans. The provisions of the "Access to Health Care Act of 1986" (S. 2403) will reduce the number of uninsured individuals by making it easier for them to get private health coverage. Such improvements will be gladly welcomed by millions of midlife women who currently have no health plan coverage.

While estimates of the medically uninsured range from 20 million to 37 million, by any count a majority of Americans under age 65 have some health insurance, most through private plans. About 85% of private coverage is group coverage, and most of that is through employment. As long as individuals are in covered employment or related to employed workers, they have health insurance.

A change of work or family status, however, too often means a loss of health insurance. While both men and women lose health coverage when unemployed or laid-off, women also lose coverage when they are widowed, divorced, or their husbands retire. Thus, health coverage for women is highly dependent on both marital and work status. Here are some examples of that interrelationship:

- Mary H. and her teenage sons lost health insurance when her husband died at age 56; she has been a homemaker for many years, and is having great difficulty in finding a job.
- Sylvia J. lost coverage at the time of divorce; her children were continued as dependents in their father's group plan at work, but she was dropped. She works full-time as a secretary in a small firm that does not have employee health insurance.
- Barbara B.'s husband retired under pressure from his employer when he turned 65. He is eligible for Medicare, but at 62, she won't be eligible for three more years. She retired from longtime employment after a mastectomy at age 60; because of her health history, she has not been able to find any affordable health insurance policy.

These are by no means isolated examples. About 5 million women between the ages of 40 and 65 have no health coverage, no protection against the costs of catastrophic illness, and limited access to any health care. Women are more likely than men to be "medically dependent" because of lower labor force participation rates, and higher rates of employment in part-time or low-wage service jobs without health benefits.

Most married women, whether in the paid labor force or not, have private health insurance. But only about half of widows and a third of divorced women not in the labor force have such insurance; among women under age 65, 40% of divorced women and 25% of widows not in the labor force depend on Medicaid.[1]

Midlife women are not only more likely to be without health coverage than men of the same age, they are also at greater risk than younger persons. While health coverage is lowest among persons ages 18-25 (due to student status or unemployment after losing coverage under a parent's plan or Medicaid), young adults are less likely to need hospital care.[2]

The Older Women's League identified access to affordable health insurance as a crucial health problem for midlife women. We developed a model state bill requiring group health insurance continuation for medically-dependent spouses, and advocated its passage in more than a dozen states. From 1981 to 1985, bills based on the model were enacted in seven states (Illinois, Kansas, Louisiana, Missouri, Oregon, Texas, and Vermont).

Mr. Chairman, as you well know, federal legislation addressing the issue of spousal health insurance continuation was first introduced in Congress in 1985, with your "Health Equity and Fairness Act," (S. 1211), Sen. John Heinz's "Health Insurance Continuation Act," and "Continued Access to Group Health Insurance Act" (H.R. 21) introduced by Rep. Pete Stark and Rep. William Clay.

With your leadership and support, provisions from these bills were included in the 1985 budget reconciliation bill, signed into law April 7, 1986 as Public Law 99-272. Once fully implemented, those provisions of PL 99-272 will protect many Americans against a sudden loss of coverage at a vulnerable time--when they are unemployed, divorced, widowed, or their spouses retire.

Since the law begins to take effect on July 1, the Older Women's League has undertaken a public information campaign on the new law. We've produced a consumer information pamphlet to answer questions that are pouring into our office; a copy is appended to this statement for the record.

But the health care access problems of uninsured Americans--or even of midlife women--are not solved by this new law. Many persons may not be able to afford the premiums to continue group coverage, or to convert to individual policies when temporary continuation ends. The law is not retroactive, and so does not help several million women who have already lost their coverage. It does not help high risk individuals who find they cannot purchase protection at any price. And it does not apply to employers with fewer than 20 employees.

Your "Access to Health Care Act of 1986" (S. 2403) and companion bills S. 2402 and H.R. 4742 address some of these problems. The bills require states to establish health insurance pools and funding mechanisms for uncompensated care, require employers to pay for continued coverage of laid-off workers for up to four months, and encourage more group coverage by small businesses and the self-employed.

OWL particularly endorses the establishment of state pools that market comprehensive health insurance to all residents regardless of health status (Section 2 of S. 2403). We believe that it is absolutely essential that state pools keep the premiums affordable. S. 2403 recognizes the medically uninsurable--those who can't get private health insurance--but there is less awareness of the financially uninsurable--those who can't afford private health insurance. Without adequate premium control or premium subsidies, we may end up with no uninsurable Americans, but millions of uninsured individuals because they can't afford to purchase coverage. If they can't pay for individual coverage, how can they afford premiums of 150% that amount?

o As written, the bill states that subsidy of an individual's premium or a premium based on income is not "prevented"; we urge the use of positive language encouraging states to build into their pools either sliding-scale premiums or some other form of assistance to individuals.

o Premiums will be less subject to large annual increases if pool funding is broadly shared by all; we believe that pool losses and subsidies should be shared by all insurers, including self-insured employers.

o Pools must not provide an incentive to employers either to drop their existing coverage or to refuse coverage to certain higher-risk workers, sending them to the pool for coverage instead; a special surcharge should be levied on all larger employers who don't provide a health plan for their employees, or who refuse to cover all employees in an existing plan.

As long as our private health insurance system is employment-based, employers must do their share to deal with those whon fall between the cracks. As another means of reducing the number of uninsured Americans, OWL supports the employer provisions of Section 4. Employers would be required to pay for continued coverage of laid-off workers for up to four months--many now extend such coverage--and to provide open enrollment for the working spouses of laid-off workers. Since such extension may come at a difficult time for employers, prefunding should be encouraged.

We also strongly support the provisions of Section 5 dealing with small businesses and self-employed individuals. As subcommittee members undoubtedly know, a high proportion of women work for self-employed persons or are employed in small businesses; particularly in the service sector, these jobs are not likely to include health insurance as an employee benefit. Providing these employers with tax incentives for establishing group plans and, through the Congressionally-mandated study, with ideas on keeping costs affordable will result in affordable group health insurance for workers and their families.

For persons with no private or public health coverage, access to health care is becoming increasingly problematic. Measures of uncompensated care don't begin to fully describe the dimensions of the problem, since they do not include those who simply don't seek needed care. All providers, insurers and consumers should equitably share in the cost of charity care. The mandates of Section 3 requiring states to set up plans for funding uncompensated care are welcomed.

The Older Women's League believes that access to affordable health care is a right, not a privilege. Our Board and members strongly supports the development of a comprehensive national health care program, with emphasis on health promotion and maintenance, available to all. To be without health care coverage in today's medical economy means either foregoing necessary treatment, using up life savings, or going disastrously into debt.

All Americans must have access to affordable health care, including long term care. As long as our health care system continues as a patchwork quilt of for-profit and nonprofit providers paid by public and private insurers (including employers, taxpayers and individuals), then we must find ways to cover those who are unprotected or inadequately protected.

We believe that this legislation represents exactly such solutions, piece-meal though they may seem to some. The Older Women's League stands ready to work with you on behalf of the "Access to Health Care Act of 1986" and we urge your colleagues to support its speedy passage.

NOTES

(1) "Women and Divorce: Health Insurance Coverage, Utilization, and Health Care Expenditures," Marc Berk, Natl. Center for Health Services Research, American Journal of Public Health 74 (Nov. 1984): 1276-1278.

(2) Detailed Diagnoses and Procedures for Patients Discharged from Short-Stay Hospitals, United States, 1984: Data from National Health Survey, Series 13, No. 86. National Center for Health Statistics, p. 4.

Hospitalizations per 10,000 population, 1984	
Under 15	620.1
15-44	1321.7
45-64	1832.8
65 and over	4003.6

Group Health Insurance Continuation

You are eligible to continue your current group health insurance coverage if you are: the widow/er or divorced spouse of a worker; the Medicare-ineligible spouse of a retiring worker; or if you or your spouse has been laid off, terminated (except for gross misconduct) or is working reduced hours. Dependent children are also covered.

The new law applies to private employers with 20 or more workers and to state and local government health plans.

You do not have to pass a physical examination, since you are already a member of the group plan. Your coverage simply continues, but you must pay the full monthly premiums —both the employer and employee portions, plus a 2% fee for administrative costs. Even so, most people will find that their current group health insurance plan is more affordable and provides better coverage than an individual policy.

The coverage ends if you fail to pay your premium, become eligible for other group coverage through employment, remarriage or Medicare, or if the employer ends group health insurance coverage for all workers.

The law is effective for health **plan years beginning after July 1, 1986.** The employer or health plan can tell you when your next plan year begins. If the plan year begins in August, the law takes effect for you in August 1986. If the plan year does not start until February, the law takes effect for you in February 1987. Some employers are voluntarily complying earlier than the law requires; check with your employer. For plans subject to collective bargaining, the law does not take effect until January 1987, or when the current bargaining agreements expire, whichever is later.

The Older Women's League is the first national membership organization to focus solely on the concerns of midlife and older women. OWL is a nonprofit organization with 15,000 members and more than 100 chapters throughout the United States.

OWL has advocated for group health insurance continuation since it was founded in 1980. OWL founder and former president Tish Sommers—who died in 1985—had been denied health insurance as a divorced woman in her early 60s because of her medical history. Six months before Sommers turned 65, the cancer that had made her ineligible for insurance recurred. Sommers was able to afford the necessary treatment, but she recognized that millions of divorced and widowed women are not so lucky.

OWL developed and actively sought passage of state legislation for group health insurance continuation for widows and divorced women. Seven states—Illinois, Kansas, Louisiana, Missouri, Oregon, Texas and Vermont—have passed legislation based on OWL's model state bill. This brochure is part of OWL's campaign to ensure that older women exercise their rights under this new federal law.

This brochure may be reproduced in whole or in part, with credit given to the Older Women's League. Single copies may be obtained by sending a stamped, self-addressed envelope to OWL. Contact OWL for information about the cost of bulk orders. Contributions and donations are welcome; membership information is available from: Insurance Continuation, OWL, 1325 G St., NW, Lower Level, Washington, D.C. 20005, (202)783-6686.

June 1986

Older Women's League

Group Health Insurance Continuation:

A New Law That May Help You Keep Your Health Insurance When Your Family or Work Status Changes

After July 1, 1986, many Americans who would otherwise lose their group health insurance coverage because of unemployment, divorce, or the death or retirement of a spouse will be able to keep their insurance—by paying their own premiums.

Older Women's League

An Introduction

Most Americans with private health insurance are covered through an employer. As a covered worker or family member, you have health coverage as long as you are employed or are related to an employed worker. But if your family or work status changes, you often lose your health insurance, too.

Women often lose health insurance coverage when they divorce, are widowed, or their husbands lose a job or retire. An estimated five million American women age 40 to 65 have no health insurance whatsoever.

Public Law 99-272, enacted in April 1986, will help many individuals retain their health insurance when work or family status changes.

This new federal law begins to take effect July 1, 1986. It may help you.

This brochure explains how to take advantage of your expanded right to continue group health insurance. It is not intended to provide legal advice. If you are divorcing, consult a lawyer before making decisions that may affect eligibility for health insurance continuation.

This new law will **NOT** help you if you have already lost your health insurance before it takes effect.

What Group Health Insurance Continuation Means For . . . .

Widows and Dependent Children

If you have health insurance through your spouse's employer, you and your children can continue that coverage for three years if your spouse dies after the group health insurance continuation law takes effect. The employer should notify the health plan when a worker dies; **check with the personnel office** to confirm this has been done. Within two weeks, the plan must notify you of your right to continue coverage. **You MUST respond** within 60 days if you wish to continue on the group health insurance plan.

Divorced or Separated Spouses and Dependent Children

If you have health insurance through your spouse's employer, you and your children can continue that coverage for three years if you divorce or are legally separated after the group health insurance continuation law takes effect. **Notify the health plan** of the change in marital status RIGHT AWAY. Within two weeks, the plan must notify you of your right to continue coverage. **You MUST respond** within 60 days if you wish to continue on the group health insurance plan.

One final note: Provision for health insurance may be included as part of a divorce decree; discuss this possibility with your lawyer. But remember that coverage ends if premiums are not paid, so **you should pay** the premium yourself and be reimbursed by your former spouse. Otherwise, late or missed payments could jeopardize your insurance.

Spouses and Dependent Children of Retiring Workers

If you have group health insurance through your spouse's employer and are not eligible for Medicare, you and your children can continue coverage for three years if your spouse retires after the group health insurance continuation law takes effect. **Check with the personnel office** to confirm that the employer has notified the health plan of the retirement. Within two weeks, the plan must notify you of your right to continue coverage. **You MUST respond** within 60 days if you wish to continue on the group health insurance plan.

Unemployed Workers and Dependents

If you have group health insurance through an employer, you and your dependents can continue that coverage for eighteen months if you become unemployed or your hours are cut after the group health insurance continuation law takes effect. This does not apply if you are terminated for "gross misconduct." The employer must notify the health plan of your termination. Within two weeks, the plan must notify you of your right to continue coverage. **You MUST respond** within 60 days if you wish to continue on the group health insurance plan.

Other Eligible Children

If you have group health insurance through your parent's employer, you can continue that coverage for up to three years if you become ineligible (for example, because of your age). Check with the plan to find out when you are no longer considered a "dependent child." **Alert the plan as** soon as you become too old to qualify. Within two weeks, the plan must notify you of your right to continue coverage. **You MUST respond** within 60 days if you wish to continue on the group health insurance plan.

Older Women's League

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July 23, 1986

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The Hon. David Durenberger, Chairman
Subcom. on Intergovernmental Relations
Senate Com. on Governmental Affairs
154 Russell Senate Office Building
Washington, DC 20510

Dear Sen. Durenberger:

Thank you for the opportunity to expand on our statement before your Governmental Affairs subcommittee on June 26.

In our testimony, I indicated our awareness that paying for continued health plan coverage for laid-off workers might come at an economically difficult time for some employers, and that some mechanism for pre-funding of these benefits might be encouraged.

At most, the maximum amount of pre-funding needed would be coverage for all employees for a full four months. This could be accomplished either as an additional premium paid to the insurance company, or if the plan is self-funded, a tax exempt reserve fund.

Such a cost could well be spread over the premiums of all employees, since everyone would be a potential recipient. We believe that most workers would welcome such protection as a kind of "insurance on their insurance."

It appears that there would be additional revenue loss to the government in the form of tax deductions for the increased cost of health insurance or the reserve fund. But four months is not a terribly long period, and such pre-funding should be allowed in spite of revenue loss, some of which would be offset by decreased pressure on Medicaid.

Finally, it would be important to insure that any provisions for pre-funding do not conflict with TEFRA and DEFRA restrictions on pre-funding of welfare plans. Some leeway may or may not exist right now, but if not, it should be allowed.

Thank you again for your leadership on the issue of increased access to affordable health care. If there is any way in which OWL can help move this issue along, please contact us.

Sincerely,

Lou Glasse

Lou Glasse
President

STATEMENT
on
"ACCESS TO HEALTH CARE ACT," S. 2403
before the
SUBCOMMITTEE ON INTERGOVERNMENTAL RELATIONS
of the
SENATE COMMITTEE ON GOVERNMENTAL AFFAIRS
for the
U.S. CHAMBER OF COMMERCE
by
Robert E. Patricelli
June 26, 1986

Mr. Chairman and Members of the Subcommittee, I am Robert E. Patricelli, Chairman of the U.S Chamber of Commerce's Health Care Council and President of the Affiliated Businesses Group of CIGNA Corporation. I appear before you in my capacity as Chairman of the Chamber's Health Care Council.

On behalf of the U.S. Chamber of Commerce, I appreciate the opportunity to comment on various provisions of S. 2403, "The Access to Health Care Act of 1986." The Chamber shares the Senate's interest in improving access to health care and addressing serious gaps in coverage. Toward this end, the Chamber's Health Care Council has established task forces on uncompensated care and retiree health care, two areas of public concern. We are in the process of assessing various options and look forward to working with the members of Congress in developing public policies that address these concerns.

Before addressing specific provisions of the proposed legislation, I want particularly to acknowledge the scope and success of the voluntary private health-care financing system that has evolved over the past two decades. Most Americans under age 65 are covered by one or more forms of private health benefits. Eighty-five percent are covered by employer-sponsored health insurance. Employers currently spend an estimated $100 billion each year on health-care benefits. As a percentage of wages and salaries, group health insurance expenditures have increased over fivefold since 1960.

The Chamber supports the present system of voluntary, nondiscriminatory, private-sector health-care benefit plans that vary in accordance with the needs and preferences of the workforce. Health-care benefits are a valuable protection for workers and their families. Employment-based group coverage is the most efficient and cost-effective means for financing health care. Clearly, the federal government has been instrumental in promoting the growth and success of this private-sector approach, primarily through tax incentives, without dictating the terms of these plans.

The Chamber continues to support positive incentives as the most appropriate way of promoting employer-sponsored health insurance. Comments on the specific elements of S. 2403 address the following:

1. TAX INCENTIVES FOR THE SELF-EMPLOYED
2. EXTENSION OF HEALTH COVERAGE FOR FORMER WORKERS
3. RISK POOLS FOR THE MEDICALLY UNINSURABLE
4. DEMONSTRATIONS FOR LOWERING HEALTH-CARE COSTS TO SMALL BUSINESSES
5. STATE INSURANCE AND UNCOMPENSATED-CARE PLANS

TAX INCENTIVES FOR THE SELF-EMPLOYED

The proposed legislation, which would extend a business tax deduction for health care purchased by unincorporated businesses -- which are virtually all small businesses -- and the self-employed, builds on the strengths of the voluntary system. It treats small businesses and the self-employed more equitably and will result in the increased availability of health-care coverage for their employees. The Chamber endorses this targeted extension of tax benefits.

The Chamber is pleased that the Senate version of the Tax Reform Act, H.R. 3838, also allows for a tax deduction for the self-employed and has urged members of the Committtee on Ways and Means to support that aspect of the Senate tax measure when it is considered in conference.

EXTENSION OF HEALTH COVERAGE FOR FORMER WORKERS

In contrast to positive incentives, the proposed legislation pursues a federal benefit mandate strategy, specifically targeted in this instance to extend coverage for laid-off workers, at the employer's expense. The Chamber traditionally has opposed and continues to oppose state and federal government requirements that mandate plan design.

There are sound reasons for this opposition. Employers face an increasingly complex and costly array of benefit mandates. The number of state mandated benefit laws has increased from fewer than 50 in 1974 to over 600 in 1985. State mandates encompass a host of provider groups and various treatment categories in addition to continuation and conversion requirements. In some instances, the states mandate coverage; in other instances, the states require that the coverage be made available at the employer's option. In all instances, self-insured plans are exempt under the Employee Retirement Income Security Act (ERISA).

An increasing number of state mandates require that mandated benefits be offered to all residents irrespective of where the insurance policy is issued. Consequently, employees of multi-state employers are covered by different sets of benefits, based solely on residence rather than on labor-management agreements.

The proposed federal mandate to extend coverage to former employees for four months at the employer's expense closely follows the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) continuation of coverage mandate. The COBRA provisions require employers to continue to make available health-care plans to various categories of former employees and family members (at the individual's expense) for periods ranging from 18 to 36 months. Imposition of federal mandates on the existing state requirements has created inordinate confusion. Enactment of additional federal mandates at this time only will compound implementation and compliance problems.

Mandated extension of coverage for laid-off workers would impose additional health benefit costs on businesses when they are least able to afford the extra burden. The adverse economic impact of such a counter-cyclical proposal requires scrutiny.

Access to basic health benefits should continue to be a national goal. The mandated benefits approach, however, has become highly fragmented and haphazard. Rather than continue in an ad hoc manner to address gaps in coverage, be it for specific groups or types of benefits, we recommend that the Congress conduct a systematic review of access and coverage gaps in a manner that permits an assessment of priorities, alternative strategies, associated costs, and appropriate federal incentives. The prevailing piecemeal approach fails to take into account the potential economic impact on American business and implications for maintaining a fiscally sound employment-based health insurance system.

The Chamber's 1984 Employee Benefits Survey indicates that employers dedicate nearly 37 percent of compensation costs to employee benefits. This includes legally required, as well as voluntarily provided, benefits. International competition is forcing many firms to assess labor costs and consider available mechanisms for reducing production costs. Certain health benefit mandates simply increase labor costs, force employers to consider benefit trade-offs, and reduce the employer's ability to meet the real needs of the employees. In some instances, if employers are faced with the prospect of health-care expenses for former employees, they will offer either less generous health plans or higher copayments and deductibles or, in the extreme, offer no health-care coverage. Alternatively, employers may offer fewer other benefits to terminated employees, such as severance benefits or job relocation or retraining services. Other employee benefits for all workers may be curtailed in order to keep overall compensation costs affordable.

The growing popularity of flexible benefit plans which enable employees to select a mix of benefits, is testament to the increasing preference for choice and flexibility in tailoring employee benefits to match individual and family circumstances.

Fiscal realities, in both public and private sectors, compel us to set priorities even among socially desirable goals. We propose that serious consideration be given to direct benefit costs and indirect economic effects of pursuing additional mandated benefits. In effect, economic-impact analysis will permit the weighing of competing public policy objectives prior to enactment of legislation. The Chamber stands ready to assist in gathering and analyzing the data needed to study this matter.

Because states have long-standing experience with health benefit mandates, some lessons may be learned. Recently several states have questioned the wisdom of the mandated benefits strategy. Since 1984, Washington state has required a social and financial impact assessment for proposed mandates. Similar legislation was enacted this year in Arizona and Oregon, and bills requiring impact assessments have been introduced in at least eight other states.

The Chamber recommends that the Congress defer consideration of additional federal health mandates. We propose a more systematic review of access and coverage issues that would take into account the multitude of state mandates, the ERISA interactions, and the implications of such benefit mandates on the private sector's capacity to finance employee benefits without forcing undesirable trade-offs.

RISK POOLS FOR THE MEDICALLY UNINSURABLE

The Chamber has not taken a formal position on the establishment of state risk pools for medically uninsurable individuals. Clearly, health coverage for this population is an important goal. Among the comments during Chamber Health Care Council discussion of this proposal is the acknowledgement that risk pools can ameliorate a part of the uninsured health-care problem. However, a number of Chamber members have raised concerns legislation that requires those employers offering health care coverage to their employees to fund any financial shortfall in the risk pool is potentially costly and is a disincentive to offer health care-insurance. These matters require further study by the Chamber and, we believe, by the Congress, as well.

DEMONSTRATIONS ON LOWERING HEALTH-CARE COST FOR SMALL BUSINESSES

The Chamber is pleased that S. 2403 acknowledges the need to encourage ways to lower health-care costs for small businesses. Traditionally, lack of coverage is greatest among smaller companies, due to their diminished ability to pay for and administer employee-benefit programs. Specific provisions of the demonstration grant authority are being reviewed by the Chamber.

The Chamber long has been involved in efforts to increase the level of health-care coverage among small businesses. The Chamber's affiliate, the Clearinghouse on Business Coalitions for Health Action, has been active in advising small firms on ways to provide health care in the most efficient manner. Likewise, the Chamber's affiliated research center, the National Chamber Foundation, has published several reports on health-care cost containment proposals that help to encourage the private-sector to provide health-care coverage. In addition, a number of state and local chambers of commerce have embarked upon innovative programs to show small businesses how they can afford to offer health-care coverage to their employees.

STATE INSURANCE AND UNCOMPENSATED-CARE PLANS

The Chamber shares the Subcommittee's concern about uncompensated care. We are concerned, however, by the bill's open-ended proposal that directs states to establish insurance programs for the uninsured and underinsured. A number of states are experimenting with various hospital uncompensated-care financing mechanisms. Ongoing state programs may offer models for other states. Any solutions adopted in this area, however, must not, discourage attention to hospital care costs or continued underfunding of costs by Medicaid and Medicare. At this time, federally mandating state insurance plans, especially in such a sweeping fashion, is quite premature.

In conclusion, the Chamber and I stand ready to work with this Subcommittee in support of legislative provisions that will increase both the availability and affordability of private health insurance coverage consistent with other economic pressures facing employers. Also, we would welcome the opportunity to explore in greater detail our proposal for closer economic and policy analysis of mandated benefits as a means for avoiding the myriad of problems posed by such a mandated benefits strategy.

Prepared Statement of Willis B. Goldbeck

My name is Willis B. Goldbeck and I have the privilege to appear before you today as the President of the Washington Business Group on Health, the only national organization created by major employers dedicated to improved health policy and cost management strategies.

The Improved Access to Health Care Initiative before us today could be viewed solely as a technical approach to closing some of the gaps in health insurance coverage. To do so would, in our opinion, fail to recognize and give credit to the bill's authors and sponsors for the major societal issues and values which we feel the bill challenges all of us to address.

Taken together, the bill's provisions really speak to two issues: the distribution of responsibility for the provision of health care coverage, and the designation of what constitutes appropriate or needed care. The latter point could be rephrased to form an even tougher challenge: what should society do to improve the health status of our population through the provision of access to health and medical care?

I would urge you to view all proposals through a screen of principles:

A. Closing gaps in coverage cannot be done only at the expense of those who provide and have coverage. A price must be paid by those who create those gaps, whether they do so by omission or commission.

B. Reaching political agreement on the design of a minimum benefit package would provide the basis for subsequently assigning responsibility for the provision of health care coverage. Minimum does not have to mean low quality, or second class service; it does mean we recognize in public policy that a well delivered minimum service is far preferable to no service at all: 37,000,000 people would certainly agree.

C. Emphasis upon acute care is a guarantee of never extricating ourselves from the financial drain caused by the current system. We must have Congressional leadership to establish a new, longer term, investment strategy that gives prominence to prevention, long term care, child care, and mental health.

D. Finally, we must accept a few basic, if unsettling facts:

1. We can afford whatever health system we want, if we (a) will buy care efficiently, (b) educate the consumer with meaningful price, service, utilization and quality comparative information, and (c) do not overspend on defense or tobacco subsidies.

2. All gains in cost management by the public and private sectors will be counteracted if we continue to experience rapid increases in the under 65 poverty rate. Producing generations of illiterate, undernourished, emotionally unstable and largely unemployable youth is not the pathway to a healthy economy or affordable health care system.

3. Our retirement system must be restructured to recognize and reward our new achievements in longevity. Neither Medicare, Social Security, nor private employer retiree medical and pension plans will ever be financed adequately to support millions of people for 20-30 years. Changes in

> education policy, work culture and retirement policy will be major determinents of health policy and economics.

As we respond to the specifics of The Improved Access to Health Care Initiative, we do so in the context of these larger issues which must someday be faced directly.

Employer obligation's

Naturally, no employers want to be required by government to give a benefit which is normally left within the purview of management-labor compensation negotiations. Equally obviously, employers cannot deny that workers who lose health insurance during job transitions or lay offs pose a problem for society as well as for themselves.

By maintaining our traditional support for an employment based health insurance system rather than a governmentally controlled national health insurance system, employers must also be willing to do their share to ameliorate the problems faced by those who fall into the cracks inherent in a private sector, increasingly market oriented structure. It was in this spirit that the WBGH supported the benefit extension in Congressman Waxman's bill to provide health insurance for the unemployed. That was in 1983 when unemployment was 10.2% and millions who had been protected by voluntary extended benefit contracts were laid off for so long that they exceeded this protection. The Waxman bill called for a three-month extension, a period of time that was considered adequate to resolve the problem for most laid off workers. Today, unemployment is 7.2 percent. Extended benefits ranging from two to twenty-four months are the norm for many major companies. Progress has been made yet, undeniably, problems still exist.

We have reviewed our position and, despite the progress achieved and the costs to be incurred, agree to continue our support for a three-month extension requirement. We believe three months is sufficient to meet the needs of transitional workers. And, we want to be very clear that we do not believe employers should be asked to protect the long term or permanently unemployed. They represent a different issue in search of a different solution.

The additional eighteen month extension, at the employee's cost, is not considered necessary due to the recent passage of COBRA which contains the same provision.

We believe the federal standard for benefit continuation should take precedent over state requirements with which the federal law is in conflict. Employees and insurance carriers should not have to be the arbitrators of the conflicts between levels of government. Currently, the states have numerous and frequently conflicting benefit continuation requirements. The passage of COBRA adds a federal requirement that increases the confusion. It is one thing to comply with the law, but it is an unrealistic burden to ask that employers and their carriers also resolve the conflicts among laws with ostensibly the same objective. We recommend that a single federal standard be adopted.

We also support the open enrollment period for employed spouses of workers who lose their jobs and their health insurance. It is assumed that such enrollment would occur after the laid off worker exhausted the benefit extension mandated by this same bill. The primary benefit obligation should rest with the employer who laid off the worker, not be shifted to the employer who continues to employ the spouse.

Pools

Both pool approaches have merit and would help groups which, by their exclusion from the existing delivery system, pose a threat to the essentially progressive movement toward a more market oriented health care system.

As advocates of market forces we must also be willing to support, politically and financially, mechanisms that bring more people into the market. The health care market will not work for employers unless it can be creatively manipulated to work for all segments of our society.

The WBGH has always believed that employers should participate in legislatively created pools whether or not the company happened to be self-insured and thus technically exempt due to ERISA. We are aware that this attitude is not always accepted.

In the proposals before this committee, the pool designs have two major flaws. By proposing to finance the pools (for all costs above those paid by pool participants) through what amounts to a tax on employers who provide insurance and the employees who share the cost of that benefit, the bill's authors are providing one more direct incentive for small and mid-sized employers to either not start, or to actually cancel, their employee health insurance benefit. This is neither wild conjecture nor a red herring scare tactic.

Today, more than 50% of the medically indigent are employed by companies that have chosen not to provide any health insurance benefit. If you add dependents to this group, some two-thirds of the indigent are connected to the workforce and could normally be covered by these private sector firms. However, these owners prefer to rely on government, either directly or through pool taxes/surcharges on fellow employers, to enable them to gain a competitive business advantage by avoiding health insurance expenditures.

As if this were not bad enough, the rapidly growing number of state and federal government mandated benefit additions and extensions provide clear reinforcement for the employers who decide not to provide benefits.

We have actual reports of employers with up to 1,000 employees who have recently dropped their health insurance plans. They will rely on the state or federal government to provide protection by some form of surcharge/tax on the major employers who are more responsible and maintain their employee and dependent health insurance benefits. What we have is the ultimate irony: the employers who do the most to provide the best coverage to the most people are the only ones who are asked to pay for the workers and dependents of other employers who elect to provide no benefit. The inequity and perverse incentive should be enough to make the bill's authors rethink their approach to financing pools.

At a minimum, the WBGH recommends that any pool surcharge/tax be levied on 100% of employers whether or not they provide health insurance. This would more equitably distribute the economic burden of meeting a societal need.

The second flaw is the basic assumption that the hospital charge for serving the indigent should be accepted by either public or private payers as legitimate. I find little objection by employers to paying a reasonable share of the true costs of meeting the health care needs of the indigent. However, you can appreciate our reluctance to accept hospital charges as having any validity. Consider that:

- Employers often find as many as 90% of large hospital bills to be incorrectly prepared.

- Neither public nor private payers should pay, through indigent care charges, for excess capacity, unnecessary tests, the failure to collect past due bills and other costs which are not the direct result of indigency.

- Teaching hospitals claim they have to be the most expensive. Why, then, is University Hospital in Iowa City, the state's only teaching hospital, less expensive than the typical community hospital in Des Moines? Is the health of the indigent enhanced by having them served in teaching hospitals out of proportion to the rest of society? And, should we, the payors, accept blindly the contention that we should pay whatever the so-called uncompensated care charges happen to be?

- DHHS reports that hospitals in general and teaching hospitals specifically have enjoyed the greatest profits in recent history. Why, then, are they not increasing their indigent care outlays instead of seeking new subsidies from government and employers?

- Surcharge/taxes that provide hospital coverage reinforce the most expensive and wasteful care giving setting at the very time we are all trying to develop non-hospital based care systems.

This leads to another WBGH recommendation: All the indigent should be served through managed care systems.

In conclusion, any pool system must be designed so it:

1. does not punish those who already are doing the most.
2. does not encourage employers to drop or avoid starting health insurance benefits.
3. does not accept existing hospital charges without a system for accountability, and
4. does not encourage unnecessary hospitalization.

None of these concerns deny the objective set forth in your bill. We only want to improve the process for achieving that objective.

Small business incentives

We strongly support your provision to provide tax incentives that will make it financially easier for self employed persons to purchase health insurance.

The studies you propose are also useful, more because they can focus attention on the subject than for any major discovery they are likely to produce. In fact, we really know the answer to the question of how small business should or can afford health insurance. The simple fact is, most small firms should not try to buy insurance separately. The product offerings are not very good and the prices are much too high for the value received. Small firms need to band together so their health insurance buying power equals that of large employers.

In some respects, this approach is like the old Blue Cross community rated plans which pool the experience of many small firms and individuals. However, there are two essential differences. The first is that the initiative is taken by the employers who form their own purchasing organization. Secondly, if employers band together, they form a group that does not have to include non-working individuals who are often high users in truly community rated plans.

Let me offer a local example. The WBGH is a very small business (less than 25 employees) and we have developed a remarkable capacity to be non-profit! We do not need extra expenses and we have no for-profit products to price so overhead like health insurance gets passed on to the consuming public. We tried to buy health insurance and found no satisfactory options. Now, we belong to the plan established by the Washington Council of Agencies. We saved at least 20% and received a better benefit. And, we were just notified that the premium increase for 1986-87 was 0%! Yes, it is possible for any small business, with a little planning, to afford a reasonable health plan.

Large employers, separately and through local coalitions, industry associations, Chamber of Commerce or universities can help small employers and their associations with purchasing, negotiations, cost management and benefit administration.

To conclude, we support many aspects of The Improved Access to Health Care Initiative and hope that you, in turn, will give our concerns the attention we feel they deserve. Employers will have to join community and nationwide efforts to make the health care market work for all, but this laudable goal will not be achieved by increasing the incentives for some employers to drop their benefits altogether.

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TESTIMONY OF BERT SEIDMAN, DIRECTOR
DEPARTMENT OF OCCUPATIONAL SAFETY, HEALTH AND SOCIAL SECURITY
AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS
BEFORE THE INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE
OF THE SENATE GOVERNMENT AFFAIRS COMMITTEE
ON ACCESS TO HEALTH CARE SERVICES

JUNE 26, 1986

The AFL-CIO is pleased to present testimony today in support of S. 2403, the Improved Access to Health Care Initiative. We in organized labor share the committee's concern about the dramatic growth over the past five years in the number of citizens without health insurance protection and, thus, without regular access to the health care delivery system. A less obvious problem, but with equally serious ramifications for policy makers, is the shocking jump in the number of individuals who are judged to have inadequate health insurance coverage. A recent study by the Washington, D.C. Government Research Corporation estimated this population to be as large as 50 million. Adding this to the 35 million known to be without any health care protection, two-thirds of whom are in the workforce or their dependents, there is a total universe of 85 million people who do not have adequate access to health care services.

The AFL-CIO strongly believes that the best medicine for this problem would be the enactment of a national health care system, which makes access to basic health care services a right for all Americans. Of all the industrialized countries except South Africa, only in the United States is health care coverage tied to one's job or other source of income and the decision whether to provide coverage left to an individual's employer. Only in the United States are individuals with chronic health care problems locked out of the system because they cannot obtain insurance protection. And only in the United States are children of the working poor and retirees who are not yet eligible for Medicare denied early treatment for potentially serious medical conditions because of a lack of protection and an inability to pay for health care services.

The problem of the uninsured and underinsured has escallated as a result of a confluence of public and private sector events. There have been cutbacks in public programs to the point where Medicaid now covers less than 50 percent of those living under the poverty line. Because of excessive increases in the cost of insurance, purchasers in the private sector have become more "price sensitive" and increasingly unwilling to subsidize the cost of care to the uninsured, which now amounts to approximately $6 billion nationally and threatens the very existence of public hospitals and "providers of last resort" for those without coverage or with inadequate protection.

We commend you, Mr. Chairman, and the other sponsors of S. 2403 for introducing legislation which could help to provide much needed health care protection for those who are currently uncovered. However, we do have a number of concerns about the bill.

First S. 2403 will address the short-term health care needs of the unemployed who, when laid off, not only experience the trauma of joblessness but also lose their link to the health care system. Although we view the requirement that employers continue coverage for four months after layoff as a positive step, it will not address the needs of the 25 percent of the unemployed who have been jobless for more than 4 months. Conceivably these individuals might have a higher probability of obtaining treatment with the enactment of the bill's requirement that states establish a mechanism to provide funding to hospitals to offset bad debt and charity care. However, a study published in the May 1, 1986 edition of the New England Journal of Medicine demonstrates what many health policy analysts have known for some time: that health care indirectly funded in this manner is far less adequate than services provided under public programs, such as Medicaid.

Second, we are concerned that, absent any targeting requirements in the bill for state insurance pools, public hospitals and other facilities serving a disproportionate share of patients without insurance protection may not receive their "fair share" of funds. We believe that the federal legislation should require states to give priority to these institutions and encourage hospitals to provide outpatient care when appropriate.

Third, although the bill attempts to limit what constitutes bad debt and charity care by specifying what would not be reimbursable under this section, it neglects to mention shortfalls as a result of hospital discounts given to large non-governmental payors. We believe that such a provision should be added to bar facilities from shifting the costs of such discounts on to state uncompensated care pools.

Fourth, we believe that somewhere in the bill a definition of "bad debt and charity care" and "underinsured" ought to be spelled out.

Fifth, if Congress intends to allow states to deal with the uninsured and underinsured problem by allowing them to set up a managed system of care, then it should specify what it means by managed care, in addition to requiring some basic quality controls to protect the health of potential participants.

With respect to the issue of requiring employers to contribute to a state pool for individuals who cannot obtain insurance protection because they are chronically ill or at high risk of becoming ill, the AFL-CIO supports the principle underlying this provision that there should be an equitable risk-sharing arrangement to distribute the cost of care for victims of chronic diseases. We have long held that individuals and their employers should not be unfairly penalized for poor health status and would view the enactment of this provision as a positive step forward. Although some states are now considering establishing such a pool, only nine have actually done so.

On the other hand, although the bill sets a maximum on premiums that can be charged to individuals participating in state risk pools, this cap will no doubt become the only rate, leaving us with serious concerns about the potential pool of eligibles who will not be able to afford such coverage. Both the premium and out-of-pocket maximums, which also are certain to become the exclusive amounts may be affordable only to families with relatively high incomes. In the interest of equity, we believe that the committee should consider instructing states to establish a sliding scale based on income for premium requirements, as well as out-of-pocket payments. Currently, the bill would merely not prohibit a state from doing so. In addition, it should be clearly spelled out in the bill that a state may not charge higher rates to those individuals with relatively poor medical histories.

Before concluding our statement, Mr. Chairman, the AFL-CIO would like to inform the Committee that it has been working with a group of its affiliated unions and consumer organizations to develop a model initiative of our own to address the needs of the uninsured and underinsured. Our model, which will be available shortly, has a federal and state component. Like S. 2403, it would offer states various options for improving access to care. However, we recommend requiring states to establish a public commission, with a majority of its members, health care consumers, to implement such a plan. It would also require that hospitals with the greatest need be targeted for relief from expenditures for bad debt and charity care, and it would set out general guidelines for case management systems and it would require hospitals that receive funds to establish systems by which outpatient care can be provided to patients in situations where inpatient care is not warranted. In addition, to the federal component, we are preparing a model state bill that would take the next step and implement the federal guidelines. At the appropriate time we would be pleased to share this model with the Subcommittee and staff.

Again, we would like to commend the Subcommittee for taking the initiative in attempting to improve access to health care services for the uninsured and the underinsured and are prepared to work closely with you to pass this important initiative.

Testimony of
Donald Hansen
President
Precise Products Corporation
on behalf of

the National Association of Manufacturers
on S.2403

Before the
Subcommittee on Intergovernmental Relations
Committee on Governmental Affairs
U.S. Senate

June 26, 1986

Mr. Chairman and members of the Intergovernmental Relations Subcommittee, I am Donald Hansen, President, Precise Products Corporation, Minneapolis, Minnesota. Today I am appearing on behalf of the National Association of Manufacturers. Accompanying me is Sharon Canner, NAM Director of Employee Benefits.

The NAM is an organization of over 13,000 corporations of every size and industrial classification located in every state. Members range in size from the very large to over 9,000 smaller manufacturing firms, each with an employee base of less than 500. The NAM is also affiliated with the National Industry Council which includes 135 state and local business associations representing 138,000 individual companies. I am an active member of my local association --- Minnesota Association of Commerce and Industry. We are pleased to be here to present our position on the Access to Health Care Act of 1986 (S.2403).

Mr. Chairman, we share your concerns with the problems of care for the medically indigent. Indeed, the NAM encourages its members to voluntarily provide various types of assistance as proposed under S.2403. However, certain provisions of the "Access to Health Care Act of 1986," would interfere with state and local programs now in place and further discourage the expansion of employment-based health insurance, the source of protection for over 85% of American workers and their families. Therefore, we cannot support this legislation.

We believe health care for the poor and the uninsured is a multifaceted problem demanding a variety of creative, thoughtful and fiscally responsible approaches. Various initiatives responding to this problem are already underway. For example, many employers voluntarily extend health insurance coverage to laid-off workers and their families, and some 34 states operate indigent care programs, while in the remaining states, most counties and municipalities have some legal responsibility for providing medical care to residents. Options, including existing regulatory authority, have been used by some to assure that institutional providers furnish care to indigents. Georgia for example, requires parties purchasing or leasing a public hospital to provide an amount of charity care equal to three percent of hospital gross revenues for the sale or lease to be approved. State and local programs are designed to reflect local needs of the respective populations.

In particular we call your attention to the following troublesome provisions:

Establishment of Statewide Insurance Pools. Under the proposal, all states would be required to form insurance pools for persons not covered by job-based insurance and for persons unable to secure coverage for other reasons. Both group insured and self-insured employers, who do not participate in the pool by covering its losses, would be subject to a 10% civil penalty levied on the amount that employer expends on health insurance.

The problems with this proposal are many. First, pool losses could be considerable since participants are likely to be those at highest risk and with the least incentive to make cost-effective use of health services; thus employers, particularly smaller ones and those in poor financial condition, would be reluctant to participate. The threat of a 10% penalty may cause employers to have lesser resources available for payment of basic wages, or might even force them to reduce the level of health benefits they do provide.

Second, pools are not appropriate for every state, as mandated federal standards fail to recognize the uniqueness of medical costs or benefit design issues relative to a particular area. Mandated state pools would also require new bureaucracies to administer the program---surely a costly undertaking for states.

Finally, since employers would have to pay for costs not covered by premiums---and costs are likely to be enormously high---the expense to the employer community will be great. It would thus be a further disincentive for employers to offer health insurance benefits to their workers in order to avoid paying into the risk pool for the employees of their competitors who do not provide benefits. Some employers may decide to forego offering health benefits altogether.

Nine states now operate risk pools, including Minnesota. As a self-insured plan, Precise Products does not participate. Doing so, as S.2403 mandates, would be a severe hardship on my company.

Major insurers in most of the states are assessed the difference between the premium income and expenses of the pool, allowing them to claim this amount as a tax deduction. Generally, states do not subsidize the pool, since these costs can be quite high due to the high risk groups participating. Similarly, asking employers generally to subsidize the losses, could also be extremely costly, seriously impacting their economic viability in some cases.

State Programs for Payment of Uncompensated and Charity Care. Under S.2403, all states would be required to develop and implement a mechanism for subsidizing uncompensated and charity care. Failure to comply would result in loss of Medicaid administratve funds.

A variety of financing mechanisms--sales taxes, cigarette taxes, general revenues, property taxes, and assessments on provider revenues--are being used by states to fund indigent care programs. A 1985 survey of states conducted by the National Governor's Association and the Intergovernmental Health Policy Project shows that the problem of indigent care is being addressed by revising the eligibility criteria for existing programs in order to reach those who do not have access to services. Rather than across the board expansions in the Medicaid area, for example, states are carefully targeting their resources to most efficiently allocate scarce resources. Young children and pregnant women are key groups because of the high benefit/cost ratio and also because of the concerns over increased infant mortality rates.

Although these programs vary in their scope and breadth of coverage, many innovations are in process and should be encouraged. It is inadvisable to mandate federal legislation before fully testing and assessing the effectiveness of existing programs. Strengthening these efforts does not require new federal legislation and, indeed such efforts could be harmed by such interference.

On the hospital side, hospital patient revenues increased 6.9 percent between 1983 and 1984, while hospital total net margin was 5.1 percent in 1984, compared to 4.2 percent in 1983, according to data reported by the American Hospital Association. Understandably, certain regions may experience higher indigent care loads and it is tempting to look for quick-fix solutions. Overall, these data do not show that the costs of indigent care have adversely impacted hospital revenues generally and federally mandated subsidization of hospital costs appears to be unwarranted at this time. Further, experience to date with the prospective payment system has not demonstrated a financially adverse inpact on hospitals.

Extension of Employment-based Health Insurance for Laid-Off Workers. This provision requires employers to cover the cost of four months of health insurance for laid-off workers (also terminated) and their dependents. An open enrollment period for employed spouses of laid-off workers is also included. Both employer and employee would continue to pay whatever share of the premium they paid before lay-off.

After four months, laid-off workers would continue this coverage for 18 months at their own expense, but at group rates, pursuant to Title X of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), signed into law just a few short months ago. (Relative to Title X we have attached a letter transmitted to the Department of Labor outlining our concerns. The letter points out current issues which should be resolved before creating an additional new mandate.)

No regulations or other guidance have yet been issued to assist employers in complying with this new law. Yet new legislation is being proposed before these provisions even go into effect on July 1, 1986. This is legislative overkill and a duplicative, confusing, and complex burden on employers who provide health care coverage to their workers.

While many companies provide varying degrees of coverge to laid-off employees, mandated company-paid health insurance will place undue hardships on small businesses. Small businesses, roughly defined as those with under 100 employees, are the greatest source of job creation in this country. A recent Bureau of Labor Statistics study reported that between 1970 and 1984, which included two recessionary periods, small business was responsible for 26 million new jobs. Legislation should not place unnecessary obstacles in the path of small business development.

This provision will also have an adverse impact on plant closures. In costing out closing a plant, companies must assess their financial viability in terms of resources they can allocate to severance pay, out-placement and job search, retraining, and employee benefits. Forcing greater allocations for health insurance will mean decreasing an employer's flexibility in assisting former workers in securing new employment or with severance pay.

The issue of job lay-off and health insurance has been a frequent subject for the Congress. In 1983, House and Senate Committees considered bills similar to S.2403. At that time, the NAM went on record supporting limited employer-paid health insurance given the existing economic conditions.

This legislative position was in response to the 1982 recession, the worst year for unemployment since World War II. Even then however, the average spell of unemployment lasted just over three months and two out of every five spells of unemployment lasted for less than one month. Data for that period show that health benefits were widely available as witness a 1983 Business Roundtable survey of its member companies which showed that seventy-two percent of respondents extended total benefits for an average of eight months. Another nine percent of firms extended partial coverage to laid-off employees for an average of about seven months. Respondents represented more than 1800 companies with 800 plant locations employing more than 500 employees. We have reason to believe that coverage has remained the same or improved since that time.

Today, the economy is growing and retraining is helping many laid-off workers to secure new jobs, and with that, access to employment-based group health insurance. Those lacking health insurance will, as of July 1, be permitted to purchase insurance at group rates for a period of 18 months as authorized under Title X of PL 99-272. For others, participation in a working spouse's health plan is an option.

Mandated extension of employer-paid health insurance as proposed would be a duplicative and onerous burden on employers and we strongly oppose such legislation.

We do support the following two provisions of the legislation:

Tax Incentives for the Self-Employed. H.R. 2403 would permit self-employed individuals to take the business tax deduction for the cost of the lowest premium they pay for health insurance for their full-time employees. Such incentives would do much to encourage health insurance coverage to those working for unincorporated businesses.

The Senate Finance Committee version of the tax bill wisely includes a similar provision and we support that particular provision.

Demonstrations on Cost-Effective Insurance for Small Firms. H.R. 2403 requires the Secretary of the Department of Health and Human Services to conduct studies and demonstration projects on ways to lower the cost of health coverage for small businesses. We support this provision as a way to highlight promising models that have assisted smaller companies to better manage their health costs.

A number of innovatve approaches, including that operated by Cleveland's Council on Smaller Enterprises, are demonstrating that reasonably priced group health insurance is being provided by smaller companies. In Cleveland, some 4,500 member companies, 40 percent of which have less than 10 employees, enjoy group health coverge through a centralized system of enrollment, service and marketing. Nearly 45,000 employees and their dependents are covered by the plan. In 1985, major program costs remained the same or declined, a major feat for companies usually at a disadvantage in obtaining cost-effective insurance contracts.

Other activities meriting study are the more than 150 business/health coalitions existing in 45 states whose aim is the management of health costs through the collective action of employers working together.

CONCLUSION

Health care for the medically indigent is a problem shared by both private and public sectors, and we are pleased to work with you in seeking constructive and responsible solutions. In February of this year, the NAM Board of Directors called attention to this issue by urging member companies to: (1) make available on a temporary basis health insurance coverage to laid-off workers and their families; (2) assist in the development of group insurance purchasing by coalitions and state associations to help smaller firms; (3) support selected expansion of Medicaid; and (4) encourage the use of managed systems of care in health programs for indigents.

We believe the first three provisions of H.R. S.2403, as noted above, are not appropriate solutions to the problems of the medically indigent. Rather, statewide insurance pools, hospital programs to finance uncompensated and charity care, and employer-paid health insurance for laid-off workers are already more appropriately being addressed within the context of existing state laws and agreements between management and labor. NAM does support the incentives for the self-employed and demonstrations on cost-effective group insurance for small firms as positive steps to dealing with this complex problem.

We hope the above comments on H.R. S.2403, will be helpful in your deliberations on the issue. Your questions are welcomed.

Employee Benefits Committee

HEALTH CARE SUBCOMMITTEE

Financing Medically Indigent Care

A Policy Statement

NAM Board of Directors

February, 1986

Background

The number of individuals unable to pay for medical care is a growing problem which has major implications for employer health care costs. In the past, payment for the medically indigent was generally built into rates that hospitals charged to private sector payers. This practice of cross-subsidization, or cost shifting, is fast becoming less well hidden given the implementation of prospective payment and diagnosis-related groups (DRGs) for Medicare patients;all payor legislation in some states; the development of a more competitive hospital product; and the growing savvy of employers in making prudent purchasing decisions on behalf of their covered workforce.

Ultimately, the costs are paid by consumers and/or tax payers and this includes corporations. As such it is important to openly acknowledge the costs rather than conceal them, and seek solutions which recognize the appropriate roles and responsibilities of government and the private sector. It is also important to note that much of the care falls disproportionately on hospitals with high percentages of beds dedicated to obstetrics, neonatal intensive care, burn care, as well as to emergency/outpatient departments particularly of larger institutions in metropolitan areas.

The steps in working toward the goal of meeting indigent care needs include openly identifying the individuals to be categorized as medically indigent, identifying appropriate and available sources of funding, and matching the particular category of indigent with the appropriate funding source. In addition, solutions to the problem should be cost effective; encourage innovation and competition; promote local alternatives as opposed to federal approaches; educate beneficiaries to be better consumers of health care; assure quality care; be administratively simple; politically realistic and above all, affordable.

Policy Recommendations

To address the needs of the medically indigent, the NAM urges member companies to:

(1) Encourage the use of managed systems of care in programs for indigents. Included are preferred provider arrangements, capitated approaches including HMOs, competitive bidding arrangements, and similar cost effective mechanisms.

(2) Support selected expansion of Medicaid with particular attention to target groups and services such as prenatal and wellbaby care, pediatric care and other selected preventive services.

(3) Support incentives to encourage more employers to make available on a temporary basis health insurance coverage to laid-off workers and their families. The aim of this assistance is to encourage individuals to seek work promptly.

(4) Support voluntary dependent coverage on a temporary basis through group health plans. Employers should be encouraged to make available coverage to widows, divorced spouses, and dependent children on an interim basis. Individuals should pursue other means of coverage to adjust to their changed circumstances.

(5) Encourage the development of group insurance purchasing, such as by coalitions and state associations of manufacturers, for purposes of assisting small businesses to provide adequate insurance for their employees in a cost effective way.

(6) Encourage the establishment of state catastrophic health insurance programs to assist those who have exhausted all available third party benefits.

(7) Encourage the establishment of state risk-sharing pools for persons unable to obtain insurance because of high-risk illnesses; provide incentives, such as tax credits.

NAM
National Association
of Manufacturers

Industrial Relations Department

June 4, 1986

David M. Walker
Deputy Assistant Secretary
Pensions and Welfare Benefit Administration
U.S. Department of Labor
Room N5677
200 Constitution Avenue, N.W.
Washington, D.C. 20201

Dear David:

Beginning on July 1st, Title X of PL 99-272 (Consolidated Omnibus Budget Reconciliation Act) requires employers to make available continuation health insurance coverage to separated and divorced spouses, dependents and those who have lost coverage due to job lay-off.

This mandate raises numerous administrative questions for employers. The following is a list of questions which we would like to see addressed by regulations being prepared by the Department.

Continuation Coverage

1. Are ancillary employer health plans (e.g., dental, vision, prescription drug, hearing) affected by COBRA?
2. Does the term "as of the time the coverage is being provided" mean "at the time the person is enrolled"?
3. Must individuals who have elected continuation coverage be permitted to move among health plan options (e.g., high-low, HMO open enrollments)?
4. May health plan design changes be extended to individuals who have exercised continuation rights?
5. How does the continuation requirement apply to HMOs?
6. How do the continuation requirements apply to health benefits offered through a cafeteria plan under IRC S 125?

1776 F Street, N.W.
Washington, D.C. 20006
(202)637-3000

Notice Requirements

7. Since the required election period must last at least 60 days after the date a qualified beneficary receives the required notice, will employers have to keep copies of notice requirements for up to 20 (in some cases 38) months as proof that notice was given?

8. Is there any time limit on when a covered employee or qualified beneficiary must notify the plan administrator of the occurrence of a divorce, a legal separation or, a dependent child ceasing to be a eligible under the plan?

Coverage

9. May continuation coverage be terminated by an employer when an individual becomes eligible for coverage under another employer's health plan?

10. Can children who cease to be dependents be charged individual (as opposed to dependent) premium?

11. If a qualified beneficiary remarries but does not thereby become covered under another group health plan, must we continue to cover him/her? I assume we need not cover his or her dependents at that point -- is that an accurate assumption? What if they are then eligible for other coverage -- again does "covered" mean "eligible for" or "enrolled"?

12. Does it apply to retirees who have medical coverage and get divorced?

State Laws

13. How will state law continuation requirements relate to the federal continuation requirement?

Qualified Beneficiary

14. Are retiring employees eligible for continuation?

Conversion

15. Must employers arrange for a conversion policy to be available to individuals when their continuation period runs out?

Premiums

16. May individuals opting for continuation coverage be rated as a separate class?

17. Why is the GNP deflator (rather than a more relevant indicator such as the medical care component of CPI) prescribed for automatically adjusting plan cost for self-insured plans?

Finally, can you give us an indication of the time frame for publishing regulations or other guidelines on Title X? To address these issues in further depth, we would be pleased to arrange a meeting of our members with your office. Thank you for this opportunity to provide input on these important regulations.

Sincerely,

Sharon

Sharon F. Canner

SFC:yab

Prepared Statement of Michael O. Roush

INTRODUCTION

Mr. Chairman, my name is Michael Roush. I am the Chief Senate Legislative Representative for the National Federation of Independent Business. On behalf of NFIB and its more than 500,000 small business owner members, I appreciate the opportunity to participate in this committee's investigation into the problems of access to private health insurance and the possible impacts of S. 2403. In brief, I will argue that for the very large majority of small business owners in America, market forces ought to be allowed to operate in this product area. The goals of affordability, product quality, and broad coverage can best be ensured by insurance industry competition and informed consumer choice. The government should take the considerable role of ensuring that both of these conditions are met in our society. It is my hope that my testimony will both discourage overbearing government intervention and foster insurance industry competition, since the bulk of my statement consists of what might be called a small business market survey. If, however, public policy dictates that the government involve itself in the provision of health insurance, my testimony provides guidelines for making that involvement more effective and less expensive than it otherwise might be, at least, as far as small employers are concerned.

The National Federation of Independent Business is a voluntary membership organization comprised of more than 500,000 small business owner members. NFIB is primarily an advocacy organization, and our focus is primarily legislative. We represent the views of our members in the state capitals of all 50 states as well as before the federal government.

NFIB polls its entire membership to establish our position on public policy issues. The majority vote of the respondents becomes the position of NFIB. In addition, on issues of great complexity and/or interest to our members, we conduct -- or have conducted for as -- much more sophisticated and indepth surveys of our membership. Such surveys are recognized by the Small Business Administration and others as valid surveys of the small business community in general*.

The following chart provides one indicator of why this is the case:

Profile of Small Business

	NFIB Membership by Industry	National Small Business Population by Industry
Retail	30%	31%
Service	28%	29%
Wholesale	8%	11%
Total Non-capital intensive	66%	71%
Manufacturing	13%	10%
Construction	13%	12%
Agriculture	5%	2%
Transportation	3%	4%
Total capital intensive	34%	28%

* William C. Dunkelberg and Jonathan A. Scott, Report on the Representativenes of the National Federation of Independent Business Sample of Small Firms in the United States, Small Business Administration, 1984.

What follows in the next section of this testimony is based upon two such surveys. One, conducted in late 1978, is entitled National Health Insurance Report on Small Business; the other is entitled Small Business Employee Benefits, and was conducted in the latter part of 1985. The concluding part of this testimony is a discussion of the public policy recommendations NFIB would make based on the above material and our public policy polling results. As Appendix A I have included polling results in this area over the last ten years.

HEALTH INSURANCE AND SMALL BUSINESS.**

Sixty-five (65) percent of surveyed small business owners provided health insurance for at least a portion of their full-time employees. Approximately two-thirds (42%) carried it for all and one-third (23%) carried it for some. Provision was directly related to firm size--the larger the firm, the more likely it was to have employee health insurance. This relationship is clear whether firm size is measured in terms of employees (Table 2) or annual gross receipts (Table 3).

Table 1

PERCENT OF SMALL BUSINESSES PROVIDING SELECTED TYPES OF EMPLOYEE BENEFITS BY BENEFIT TYPE AND PERCENT OF FULL-TIME EMPLOYEES COVERED IN EACH FIRM

	PERCENT OF FULL-TIME EMPLOYEES COVERED IN EACH FIRM					
EMPLOYEE BENEFIT	None+	1-39%	40-60%	61-99%	100%	Total
Health Insurance	36	8	5	10	42	100%
Dental Insurance	84	2	1	2	11	100%
Retirement Plan	74	3	2	4	18	100%
Paid Vacations	23	7	3	8	59	100%
Paid Sick Leave	52	7	3	4	34	100%
Long-Term Disability	80	3	2	3	12	100%
Life Insurance	51	6	4	6	33	100%
Education Assistance	77	6	1	3	13	100%
Employee Discounts	61	2	2	3	32	100%
Flex-Time	82	8	3	2	7	100%
Paid Lunch Break	75	4	2	2	18	100%
Dependent Care	95	1	*	1	3	100%2Legal
Assistance	97	1	1	*	2	100%

Number of Respondents = 1,439

+ includes no answer
* less than 0.5%

+/ No answers can reasonably be interpreted as a random phenomenon or as a negative response. The former interpretation leads to distributing non-respondents proportionally across all answers; the latter interpretation leads to adding non-respondents to the negative column. The negative response interpretation was selected after reviewing individual questionnaires. It was evident from those documents that the intention of most non-respondents was to indicate a negative answer.

** See Appendix B on how the survey was conducted.

Table 2

PERCENT OF SMALL BUSINESSES PROVIDING THE MOST COMMONLY PROVIDED EMPLOYEE BENEFITS BY COMMON BENEFIT TYPE AND FIRM SIZE

	FIRM SIZE (FULL-TIME EMPLOYEES)							
MOST COMMON BENEFITS	1-4	5-9	10-19	20-49	50-99	100+	No Answer	Total
Paid Vacations								
Provided All	55	69	70	66	70	85	21	59%
Provided	18	18	22	27	29	16	5	18%
Not Provided	27	13	8	7	2	*	74	23%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Health Insurance								
Provided All	32	51	54	54	58	74	14	42%
Provided	17	28	29	34	36	15	9	23%
Not Provided	51	20	17	12	7	10	77	36%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Paid Sick Leave								
Provided All	35	37	38	36	32	49	12	34%
Provided	11	12	19	22	36	21	5	14%
Not Provided	54	51	43	42	32	31	83	52%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Life Insurance								
Provided All	21	39	46	41	56	80	14	33%
Provided	9	17	23	30	36	21	3	16%
Not Provided	70	44	30	29	9	*	83	52%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Employee Discounts								
Provided All	35	36	33	31	20	36	17	32%
Provided	7	6	10	8	12	3	5	7%
Not Provided	59	59	58	60	68	62	78	61%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Retirement Plan								
Provided All	9	16	28	31	54	56	6	18%
Provided	5	9	11	13	20	13	3	8%
Not Provided	86	76	61	57	26	31	91	74%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Number of Resp.	534	299	209	144	59	39	155	1439

* less than 0.5

Table 3

ANNUAL GROSS RECEIPTS OF SMALL BUSINESSES BY PERCENT OF FULL-TIME EMPLOYEES COVERED WITH EMPLOYER PROVIDED HEALTH INSURANCE (in percent)

ANNUAL GROSS RECEIPTS ($000's)	PERCENT OF FULL-TIME EMPLOYEES COVERED IN EACH FIRM					
	None+	1-39%	40-60%	61-99%	100%	Total
Less than 100	81	4	1	2	12	100%
100-199	59	7	5	7	23	100%
200-499	40	10	4	9	38	100%
500-799	26	10	4	13	47	100%
800-1,499	19	8	6	17	51	100%
1,500-2,999	8	7	8	14	63	100%
3,000-4,999	10	11	9	9	62	100%
5,000-9,999	11	4	4	13	70	100%
10,000 or More	6	4	4	17	70	100%
No Answer	38	8	6	9	40	100%
Percent of Respondents	36%	8%	5%	10%	42%	100%
Number of Respondents	517	110	66	149	597	1439

+ includes no answer

Benefits and Conditions

Hospitalization/surgical insurance covers those components of health care provided by a hospital and the "usual, customary, and reasonable" charges for surgical procedures performed. Major medical covers expenses beyond basic hospital and surgical benefits. And, a form of major medical known as comprehensive consists of major medical coverage "plus." These are the general types of health insurance (excluding such additions as dental) from which small employers can choose. Unfortunately, the comprehensive variation was inadvertently omitted from the questionnaire, limiting somewhat the analysis that could be performed on types of health insurance purchased by small business owners.

Over 80% of all respondents with health insurance reported carrying the most comprehensive benefit coverage listed on the survey, i.e. hospitalization/surgical and major medical (Table 4). Just 8% provided lesser coverage, and 10% either didn't reply or didn't know. There was some evidence that smaller firms were more likely to provide lesser kinds of coverage and vice versa, but the relationship was surprisingly weak.

Approximately one-third of those with health insurance did not provide it to all full-time employees. ("Non-discrimination" rules allow diffferent benefits or levels of benefits to be provided to different employee groups under specified conditions.) Table 5 reviews the conditions upon which some full-time employees were excluded from the plan. In almost half of the cases, a specified number of years on the job was the basis for inclusion/exclusion. (Later, the relationship between employee turnover and coverage will be visited.) Level of responsibility was the second most frequent point of distinction.

Eighty-six (86) percent provided an option for dependent coverage; just 3% indicated no dependent coverage was available. Those without dependent coverage tended to be among the smaller firms and vice versa. However, in no size class did the dependent coverage option fall below 74%. Only 8% of those carrying insurance provided part-time employees with the same health benefits as provided full-time employees. Virtually none provided a reduced level of coverage for part-time employees, illustrating the impracticality for most small businesses of carrying more than one coverage. Given the fact that 18% had no part-time employees, the number covered was actually higher than 8%. However, it is clear that comparatively few part-time employees working in small businesses received employer-sponsored health insurance benefits.

While the survey could not obtain more specific data on the level of health insurance provided, it appeared that once offered, the quality of insurance provided was reasonably uniform. There seemed to be little progression in benefit levels. In other words, a small business apparently did not initially offer minimal coverage, e.g., hospitalization only, and then move toward a better plan for benefit progression. Rather inclusion and exclusion of employees appeared to substitute. Though further evidence will be needed to confirm (or refute) this observation, temporarily assuming its accuracy, the second order question quickly becomes whether the employer decision is purposeful or whether insurance pricing is structured to force the decision.

Table 4
TYPE OF HEALTH INSURANCE PROVIDED SMALL BUSINESS EMPLOYEES
BY ANNUAL GROSS RECEIPTS OF SMALL BUSINESSES
(in percent)

INSURANCE TYPE	ANNUAL GROSS RECEIPTS ($000's) Under 200	200-799	800-1,499	1,500-4,999	5,000 or More	No Answer	Total
Hospitalization/ Surgical	2	*	*	2	2	3	3%
Major Medical	8	4	6	5	4	6	5%
Hospitalization/ Surgical and Major Medical	78	79	80	88	88	76	82%
Don't Know/No Answer	13	13	10	6	10	15	10%
Total	100%	100%	100%	100%	100%	100%	100%
Number of Resp.	120	312	159	198	100	33	922

NA A few large small businesses reported both voluntary and compulsory benefit levels that were considerably "out-of-range." While there is no question of the data's authenticity, additional work is required before they can be reported. Until then, the maximum allowable cost for purposes of calculating an all firms average is $9,999 per month.

Table 5

SELECTED CONDITIONS OF EMPLOYEE HEALTH INSURANCE COVERAGE BY INDUSTRY
(in percent)

SELECTED CONDITIONS	INDUSTRY										
	Con	Mfg	Trn	Whl	Ret	Agr	Fin	Ser	Prf	N/A	Total
Basis for Coverage+											
Years on the Job	22	13	11	6	15	28	6	14	9	29	14%
Certain Wage or Salary Level	3	2	3	2	4	6	*	7	*	14	3%
Age	*	2	*	1	2	3	3	3	*	14	2%
Level of Responsibility	8	4	11	5	10	14	3	7	3	43	7%
Other	7	3	8	5	4	*	10	8	5	*	5%
None	60	76	67	81	65	49	78	61	83	*	69%
Option for Dependent Coverage											
Yes	86	92	87	89	82	72	91	79	91	86	86%
No	1	1	*	2	6	11	1	7	5	*	3%
No Answer	13	7	13	9	12	17	7	14	5	14	11%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Part-Time Employee Coverage											
No Part-Time Employees	32	23	32	17	9	11	16	22	11	14	1[illegible]
No Coverage	27	41	32	42	46	50	30	46	41	57	40%
Less Coverage Than Full-Time	*	3	*	2	1	*	*	1	*	*	1%
Same Coverage As Full-Time	8	4	3	6	10	8	10	9	20	*	8%
No Answer	34	30	34	34	35	31	44	22	29	29	33%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number of Resp.	120	155	38	103	226	36	81	90	66	7	922

+respondent could mark more than one answer
* less than 0.5%
N/A no answer

Trends in Coverage

Health insurance coverage appears to be increasing in the nation's small businesses, though the proportion of small business employees covered remains significantly less than the proportion covered in large and mid-sized enterprises. The 65% of responding small business owners now reporting at least some full-time employee coverage (See Table 2) represented an eight percentage point increase from 1978 when a similar survey reported 57% coverage.*/ The retail, finance, and professional services industries were largely responsible for the rise (Table 6). All three industries experienced increases from the 1978 survey of more than 10 percentage points. Transportation/Communication also appeared to have experienced a considerable increase, but the sector's small sample size (n=37 and n=53) allowed no conclusions. The troubled agricultural industry was the only sector which reduced coverage over the period.

Since the retail, finance, and professional service industries tend to consist of firms smaller than average, the increased number of firms now providing employee health insurance can also be tied to greater coverage among smaller firms. Unfortunately, a direct comparison of coverage by firm size as measured in annual gross receipts is almost meaningless. With the Consumer Price Index having risen by 66% over the period, inflation has changed the value of a specified level of gross too much to compare response classes. However, it can be observed that the largest firms were no more inclined to provide health insurance in 1985 than they were in 1978, and perhaps even a little less. By elimination, the smallest firms then were those left to account for the greater coverage.

The overall quality of health insurance plans, i.e. coverages, costs, deductibles, etc. appeared to have also changed. Unfortunately, a comparison between quantity (number with plans) and quality (composition of plans) is difficult at best, but it is exacerbated by the data available. Quantity for present purposes was measured over a seven-year interval employing two different surveys. Quality was measured over a three-year interval employing one survey and the recall of respondents. Complicating matters, changes in the first four years were probably significantly different from those in the last three.

Despite these data limitations, small business owner responses in 1985 suggested considerable change in the characteristics of health benefits provided over the past three years, though on balance only modest improvement (Table 7). For example, the number increasing the percentage of employees covered was three times as great as the percentage decreasing. Benefits were increased by 26% compared to 14% reducing them. But the size of deductibles rose in 38% of the cases; co-insurance requirements rose as well. Costs (premiums) for both employers and employees rose, but employers were far more likely to have experienced one. In fact, three of four reported their premium cost higher than three years prior, but just one of four reported the employee premium cost higher. As many as 36% failed to respond to aspects of change in health insurance coverage. Since only responses from those with coverage three years ago were counted, it would appear that many owners were not familiar with the details of the plan they provide.

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*/ National Health Insurance Report for Small Business (National Federal of Independent Business San Mateo, CA), June, 1978.

Table 6

PERCENT OF SMALL BUSINESSES PROVIDING
EMPLOYEE HEALTH INSURANCE BY
INDUSTRY - 1978 AND 1985

INDUSTRY	YEAR		PERCENT CHANGE 1978-1985
	1978	1985	
Construction	66	73	+11
Manufacturing	81	83	+2
Transportation	60	73	+22
Wholesale	73	73	0
Retail	46	58	+26
Agriculture	52	48	-8
Financial Services	56	65	+16
Services	48	52	+8
Professional Services	49	62	+27
ALL FIRMS	57%	65%	+14

Table 7

PERCENT OF SMALL BUSINESSES EXPERIENCING
CHANGES IN EMPLOYEE HEALTH INSURANCE
COVERAGE OVER PAST THREE YEARS
(Excluding firms not in business or without
coverage three years ago)

COVERAGE	HEALTH INSURANCE CHANGES				
	Decrease	No Change	Increase	No Answer	Total
Percent of Employees	5	53	20	22	100%
Benefits	14	39	26	21	100%
Premium Cost (employer's)	4	6	75	16	100%
Premium Cost (employee's)	2	38	27	33	100%
Deductibles	4	35	38	23	100%
Co-Insurance Requirements	1	52	11	36	100%

Number = 828

Costs

It is not news that health insurance premiums are expensive. The average firm purchasing insurance spent approximately $1,750 per month for coverage--more than double the sum spent in 1978 (Table 8). (Health care costs rose 84% over the period.) Moreover, health insurance premiums amounted to a substantial portion of the total cost of an employee's benefit package. Compare the data on Table 8 to the data on Table 9. Note that the mean monthly health insurance cost was $1,766 and the estimated mean monthly benefit cost was $2,392. That implies health insurance accounted for nearly 75% (in costs) of total voluntary benefits provided. That comparison can be misleading, however. The potential for deception is best illustrated in the less than $100,000 annual gross receipts classification where the health premiums were larger than the total amount of voluntary benefits. The reason was that the total benefit figure was based on the 938 respondents; the total health premium figure was based on the 794 respondents. Nevertheless, it is clear that health insurance costs constituted a very large share of a small business's employee benefits package no matter how it is measured.

Table 10 places these health insurance cost figures in a more understandable form. The median (50% above-50% below) small employer cost of insurance per employee lay between $75 and $99 per month. However, the average was drawn higher due to the nearly 20% absorbing a monthly cost of $150 or more. The median cost per employee with dependent coverage amounted to somewhat more than $125.

Part of the reason small employers faced such large health insurance costs was that more than 2/3 paid the entire premium, and a whopping 87% paid more than half (Table 11). (Both figures cited adjust for the 10% no answer.) Curiously, 72% of those with insurance and annually grossing $100,000-$199,999 picked up 100% of the premium (over 80% adjusting for no answer). The figure fell into the 60's among those firms grossing $200,000 to $4,999,999, then into the 40's among firms grossing more than $5,000,000. This somewhat surprising distribution may be the result of administrative costs and bother in deducting the employee's share when few employees are affected; wages can be adjusted more easily. It also might reflect an emulation by small businesses with greater than 50 employees of large and medium sized enterprises where the trend has been toward a reduced employer share.

Table 8

MEAN MONTHLY EMPLOYER HEALTH INSURANCE PREMIUMS COSTS BY SMALL BUSINESS BY ANNUAL GROSS RECEIPTS AND SMALL BUSINESS INDUSTRY - 1978 and 1985

1978 ANNUAL GROSS ($000's)	1978 Mean Monthly Premium	1985 Mean Monthly Premium	1985 ANNUAL GROSS ($000's)
Under 50	$ 167		
50-99	$ 168	$ 460	Under 100
100-199	$ 327	$ 383	100-199
200-349	$ 396		
		$ 718	200-499
350-799	$ 558		
		$ 974	500-799
800-1,499	$ 958	$1,137	800-1,499
1,500 or More	$2,268		
		$2,435	1,500-2,999
		$3,134	3,000-4,999
		$4,871	5,000-9,999
		NA	10,000 or More
ALL FIRMS	$ 838	$1,766	ALL FIRMS

INDUSTRY	1978 Mean Premium	1985 Mean Premium	Percent Change 1978 to 1985
Construction	$ 868	$1,492	72%
Manufacturing	$1,805	$3,552	97%
Transportation	$ 538	$1,624	202%
Wholesale	$ 833	$1,898	128%
Retail	$ 504	$1,090	116%
Agriculture	$ 677	$1,426	111%
Financial Service	$ 836	$1,346	61%
Services	$ 541	$1,469	172%
Professional Service	$ 451	$1,445	200%
ALL FIRMS	$ 838	$1,766	111%

NA A few relatively large businesses reported health insurance premiums that were considerably "out of range." Treatment of these data is outlined in Table 9.

Table 9

ESTIMATED MEAN EMPLOYER COST OF VOLUNTARY BENEFITS AND HEALTH INSURANCE BY SMALL BUSINESS ANNUAL GROSS RECEIPTS

ANNUAL GROSS RECEIPTS ($000's)	Mean Monthly Cost of Voluntary Benefits	Number	Mean Monthly Cost of Health Insurance	Number	Per Firm Health Insurance As A % of All Voluntary Benefits[1]	Population Health Insurance As A % of All Voluntary Benefits[2]
Under 100	$ 348	64	$ 460	30	132%	62%
100-199	$ 701	110	$ 383	78	55%	39%
200-499	$1,074	190	$ 718	154	67%	34%
500-799	$1,469	128	$ 974	107	66%	55%
800-1,499	$2,081	144	$1,137	148	55%	---
1,500-2,999	$3,748	120	$2,435	117	65%	63%
3,000-4,999	$4,397	60	$3,134	55	71%	65%
5,000-9,999	$6,291	48	$4,871	40	77%	64%
10,000 or More	NA	47	NA	40	---	---
No Answer	$2,707	27	$2,080	25	77%	71%
ALL FIRMS	$2,392	938	$1,766	794	74%	63%

[1] Calculated by dividing the mean monthly cost of health insurance by the mean monthly cost of voluntary benefits.

[2] Calculated by dividing the sum of health insurance costs in each size class (not shown) by the number in each size class reporting a voluntary benefits cost. The result was divided by the mean monthly employer cost of voluntary benefits.

NA A few large small businesses reported both voluntary and compulsory benefit levels that were considerably "out-of-range." While there is no question of the data's authenticity, additional work is required before they can be reported. Until then, the maximum allowable cost for purposes of calculating an all firms average is $9,999 per month.

Table 10

PERCENTAGE DISTRIBUTION OF EMPLOYERS' COSTS IN PROVIDING HEALTH INSURANCE FOR INDIVIDUAL EMPLOYEES AND DEPENDENTS

	Individual Employee			Employee and Dependents	
EMPLOYER'S SHARE OF MONTHLY PREMIUM PER EMPLOYEE	Total	Total-N/A Excluded	EMPLOYER'S SHARE OF MONTHLY PREMIUM PER EMPLOYEE	Total	Total-N/A Excluded
$ 0-9	1	2	$ 0-24	9	11
$ 10-24	2	3	$ 25-49	3	4
$ 25-49	10	13	$ 50-74	8	10
$ 50-74	20	26	$ 75-99	7	9
$ 75-99	16	20	$100-124	10	13
$100-124	8	11	$125-174	17	23
$125-149	5	6	$175-224	12	15
$150 or more	15	19	$225 or more	11	14
No Answer	23	--	No Answer	23	--
TOTAL	100%	100%	TOTAL	100%	100%
Number of Resp.	992	713	Number of Resp.	922	706

Table 11

ANNUAL GROSS RECEIPTS OF SMALL BUSINESSES PROVIDING EMPLOYEE HEALTH INSURANCE BY EMPLOYEE SHARE OF HEALTH INSURANCE PREMIUM (in percent)

	EMPLOYEE PREMIUM SHARE						
ANNUAL GROSS RECEIPTS ($000's)	None	1-24%	25-49%	50-74%	75-99%	100%	No Answer	Total
Under 100	63	9	6	6	*	*	17	100%
100-199	72	8	4	2	1	1	11	100%
200-499	62	5	8	10	*	2	13	100%
500-799	64	8	9	3	1	3	11	100%
800-1,499	62	9	10	8	1	1	8	100%
1,500-2,999	67	9	7	10	2	1	5	100%
3,000-4,999	63	9	8	9	2	2	8	100%
5,000-9,999	44	10	20	14	*	*	12	100%
10,000 or More	44	12	14	18	*	2	10	100%
No Answer	46	12	15	6	*	3	18	100%
Percent of Resp.	62%	8%	9%	9%	1%	1%	11%	100%
Number of Resp.	567	76	83	78	7	13	98	922

* less than 0.5%

Carriers and Sponsors

A majority (53%) of small business owners carried their health insurance with a private carrier other than Blue Cross/Blue Shield (Table 12). From the comparatively few respondents specifying one of these carriers, the Travelers appeared to serve the largest number. The "Blues" carried 24%. Self-insurance (4%) and HMO's (3%) remained an oddity. Sixteen (16) percent did not respond. With the exception of self-insurance, which naturally was confined to those with $5 million or more in annual gross receipts, the carrier seemed unrelated to either industry or firm size.

The firm itself was the most frequent group sponsor (45%), followed by trade or business associations (27%) (Table 12). But among some industries, there was a far greater propensity to have association, sponsored plans than among others. For example, owners of professional service and financial service firms procured their employee health insurance through trade associations with twice the frequency as did owners of manufacturing and agricultural firms (Table 13). No immediate explanation for these differences was apparent. The most obvious, firm size which was directly related to industry, showed no relationship to group sponsor. The comparative strength or marketing capacity of varying trade groups may provide the answer, but the survey did not collect information regarding association membership.

Table 13 provides evidence of a major shift in group sponsors over the past seven years. The trade association has been increasing in importance at the direct expense of the individual firm. In fact, proportionately distributing no answers as was done on Table 13, the net increase in firms providing health insurance was almost identical to the net increase in the number of firms with an association sponsor. But the results were mixed when assessing whether or not the trend toward trade associations as sponsors has been a factor in increasing insurance coverage in those industries principally responsible for the overall small business increase. Recall that it was growth in the financial services, professional services and retail as well as smaller firms that were largely responsible for the increase in the number of firms covered between 1978 and 1985. Neither the retail nor the financial services industries shifted group sponsorship to to the degree the total population did. Professional services, however, showed the most radical shift to association sponsorship (19 percentage points). Unfortunately, a comparison with 1978 could not be made since that data could not be recaptured. Another piece of data -- the reduced incidence of smaller firms citing an inability to obtain group insurance -- also suggests that trade associations may have been helpful to the smallest firms.

Table 12

INSURANCE CARRIER OF SMALL BUSINESSES PROVIDING EMPLOYEE HEALTH INSURANCE BY GROUP SPONSOR
(in percent)

	GROUP SPONSOR					
INSURANCE CARRIER	Firm	Trade Assoc.	Self-Insured	Other	No Answer	Total
HMO	4	2	3	*	2	3%
Self-Insured	1	4	46	*	2	4%
Blue Cross/ Blue Shield	31	26	14	9	12	24%
Other Private	60	65	37	87	24	53%
No Answer	4	4	*	4	61	16%
Total	100%	100%	100%	100%	100%	100%
Number of Resp.	414	251	35	23	199	922

* less than 0.5%

Table 13

PERCENTAGE DISTRIBUTION AND CHANGE IN DISTRIBUTION OF GROUP SPONSORING SMALL BUSINESS EMPLOYEE HEALTH INSURANCE - 1978 AND 1985

	YEAR		PERCENT CHANGE
GROUP SPONSOR	1978*	1985@	1978-1985
Firm	70	57	-19
Trade Association	25	35	+40
Construction	(23)	(36)	(+57)
Manufacturing	(11)	(21)	(+91)
Transportation	(33)	(37)	(+12)
Wholesale	(24)	(40)	(+67)
Retail	(33)	(36)	(+ 9)
Agriculture	(19)	(25)	(+32)
Financial Services	(43)	(47)	(+ 9)
Services	(29)	(30)	(+ 3)
Professional Services	(33)	(52)	(+58)
Other	5	8	+60
TOTAL	100%	100%	--

* estimated from data in 1978 report
@ distributing a 22% no response
() subtotals

Satisfaction With Insurance

Almost 2/3 (66%) of the small employers providing at least some health insurance coverage were generally satisfied with the plan made available to their employees (Table 14). While at first blush a 66% satisfaction rating would seem favorable, it was 16 percentage points lower than the 1978 evaluation. The change from 1978 should not be surprising given the very large increases in premiums paid (see Table 9). Note, for example, that the percent indicating "not satisfied, but can't afford a better plan" rose seven percentage points over the period. In addition, Table 15 shows that those with less costly plans were more often satisfied than were those with more expensive plans.

Satisfaction appeared unrelated to either the plan carrier or the group sponsor. But as expected, satisfaction was related to the amount of time spend investigating health insurance options, health care cost reduction alternatives, etc. The more dissatisfied the small business owner was with his insurance, the more time he spent looking for alternatives. However, a variety of factors intervened to reduce the strength of the satisfaction/search relationship.

Table 14

PERCENTAGE DISTRIBUTION OF SMALL BUSINESS OWNER
SATISFACTION WITH EMPLOYEE HEALTH
INSURANCE - 1978 AND 1985

	YEAR	
SATISFACTION	1978	1985
Generally Satisfied	82	66
Not Satisfied, Can't Afford Better	9	16
Not Satisfied, Soon Will Have Better	2	3
Soon Will Reduce Coverage	*	1
Soon Will Drop Coverage	N/A	*
Subject to Union Agreement	3	2
No Answer	4	11
TOTAL	100%	100%

* less than 0.5%
N/A not asked

Table 15

SMALL BUSINESS OWNER SATISFACTION WITH EMPLOYEE
HEALTH INSURANCE PLAN BY EMPLOYER'S COST
(in percent)

SATISFACTION	EMPLOYER'S COST PER INDIVIDUAL ($'s) Less Than 50	50-99	100-149	150 or More	No Answer	Total
Generally Satisfied	78	76	66	65	44	66%
Not Satisfied, Can't Afford Better	19	16	21	18	11	16%
All Others	2	5	7	15	6	6%
No Answer	*	4	6	2	39	11%
Total	100%	100%	100%	100%	100%	100%
Number of Respondents	127	330	122	134	209	922

* less than 0.5%

Searching for Health Care

Small business owners are busy people; their time is often their greatest asset. Thus, it should not be startling that few small business owners personally spent much time searching for health insurance options, means to control health care costs, etc. But it is startling that neither they nor a designated employee spent much time considering options to the rapidly escalating cost of health insurance and health care.

The median time spent (owner or designated employee) investigating health care options within the last 12 months was about four hours or one-half day (Table 16). Clearly, those that had coverage spent more time than those who did not, but not by the margin one might have expected. Moreover, those covering a greater proportion of full-time employees did not spend appreciably more time than did those covering a lesser proportion.

The most noticeable cell on Table 16 is the one indicating that 41% of those without insurance spent less than one hour within the last year looking at health care options. This group probably consisted for the most part of those not interested in locating coverage. But, there were also many who spent a reasonable time searching and simply could not find something to meet their needs.

The amount of time spent searching was clearly reduced by the dependence on outside advisors. In the overwhelming majority of instances (over 60%), small business owners relied on outside professionals to provide them information on health insurance and health case costs, options, etc. The single most important source of that information, and by overwhelming margins, was the insurance agent. Forty-four (44) percent of all respondents cited this source, followed by trade associations (16%), insurance brokers (15%), magazines/publications (4%), health care providers (2%), business consultants (2%), and other (1%); 16% did not respond (Table 17). Curiously, the amount of owner/employee time spent searching increased with reliance on brokers and consultants, but decreased with reliance on agents. The opposite would have been expected. Brokers and consultants effectively become employees when engaged for certain purposes; their incentive is to reduce client costs. The incentive for agents is somewhat different.

Table 16

SMALL BUSINESS OWNER OR EMPLOYEE HOURS SPENT INVESTIGATING HEALTH CARE OPTIONS IN LAST 12 MONTHS BY PERCENT OF FULL-TIME EMPLOYEES COVERED IN EACH FIRM
(in percent)

	PERCENT OF FULL TIME EMPLOYEES COVERED IN EACH FIRM					
HOURS SPENT IN LAST 12 MONTHS INVESTIGATING	None+	1-39%	40-60%	61-99%	100%	Total
Less Than One	41	28	24	13	19	27%
1-4	14	19	18	20	20	18%
5-8	9	16	15	18	14	13%
9-16	5	13	12	17	13	11%
17-24	2	3	5	4	7	4%
25-40	3	6	11	11	8	7%
41-80	1	4	5	7	6	4%
81 or More	*	2	*	1	5	3%
No Answer	25	11	11	9	6	14%
Total	100%	100%	100%	100%	100%	100%
Number of Resp.	517	110	66	149	597	1439

* less than 0.5%
+ includes no answer

Table 17

MOST IMPORTANT HEALTH COST INFORMATION SOURCE FOR SMALL BUSINESS OWNERS BY HOURS SPENT INVESTIGATING HEALTH CARE OPTIONS IN LAST 12 MONTHS

(in percent)

MOST IMPORTANT INFORMATION SOURCE	HOURS SPENT INVESTIGATING IN LAST 12 MONTHS						
	Less Than One	1-4	5-8	9-16	17 or More	No Answer	Total
Insurance Agent	51	55	54	47	42	10	44%
Insurance Broker	7	15	19	24	30	3	15%
Trade Association	18	21	15	16	16	4	16%
Health Care Providers	3	1	4	1	2	2	2%
Magazines/ Publications	5	4	3	4	4	1	4%
Business Consultant	1	*	2	3	4	1	2%
Other	2	*	*	1	1	*	1%
No Answer	13	3	2	4	1	80	16%
Total	100%	100%	100%	100%	100%	100%	100%
Number of Resp.	395	256	184	152	255	197	1439

* less than 0.5%

Minimum Coverage Requirements

At least 20 states now require that any business providing employee health insurance include minimum levels of coverage for particular health conditions. For example, Massachusetts mandates that employer based health insurance include certain levels of mental health coverage. While still reasonably new, a question arises on the impact or influence of such public policy given that economic causes are frequently cited for non-coverage.

Table 18 illustrates that comparatively few small employers recognized that minimum coverage requirements exist. Just 6% reported their state had such requirement; 26% didn't know if their state did or not. Grouping the states with minimum coverage and those without, then distributing the small business population among them, the percent recognizing the requirement was only a fraction of those to which it applied and for which they were paying. The reason so few recognized those minimum coverage requirements is obvious. The additional coverage is wrapped in the new policy and given to the small business owner on a "take it or leave it" basis.

Of the 6% recognizing minimum coverage requirements, two of three indicated they did not change coverage in response. The next largest group expanded coverage to comply, with only a smattering claiming to have either shifted or dropped coverage. But the sample numbers are far too small to make any generalizations.

Table 18

PERCENTAGE DISTRIBUTION OF SMALL BUSINESS OWNER AWARENESS OF AND CONSCIOUS RESPONSES TO STATE MINIMUM COVERAGE REQUIREMENTS

MINIMUM CHANGE REQUIREMENTS	AWARENESS OF REQUIREMENTS	CONSCIOUS RESPONSES
Yes	6	
No Change in Coverage		66
Coverage expanded		22
Shifted Coverage		4
Dropped All Coverage		1
Doesn't Affect Me		1
No Answer		6
Subtotal		100%
No	68	
Don't Know	26	
TOTAL	100%	

Non-Coverage

Despite the increased number of small business owners providing employee health insurance, over one-third provided none; others did not provide it for all employees. The reason(s) for pursuing the no insurance option were neither surprising nor irrational. While no single reason dominated, almost all fell under the general headings of work force composition or cost.

"Generally covered under a spouse or parent policy" was the single most frequently given reason (29%) (Table 19). In other words, the employee mix consisted of significant proportions of secondary wage earners. Covering this group presumably increases labor costs without providing any additional benefits to employees. Table 19 reveals that the secondary wage earner issue was the primary reason firms with coverage often did not include all employees in the benefit. "Employee turnover too great," a second labor force composition reason, was more frequently cited by larger employers (Table 20). Recall that in the previous discussion of benefit conditions, employee tenure was the most frequently used method to separate eligibility for health insurance benefits where such separation existed (Table 4).

It was often a simple matter of economics for employers who provide no health insurance. Half of those without insurance either attributed their action to premiums being too high (33%) or to insufficient profitability (20%)--opposite sides of the same proposition. Not surprisingly, these economic reasons were most pronounced among those with coverage for no full-time employees.

Another 19% said the firm could not qualify for group coverage, which implies another variant of the cost problem. The inability to qualify as a group (real or perceived) was focused among the respondents employing 1-4 people (Table 21). Sixteen (16) percent of the very smallest employers cited it. Moreover, almost all who believed they could not qualify for group coverage indicated the reason was business size.

Despite additional response categories in the 1985 survey, the distribution of reasons for not having employee health insurance in 1985 was similar to distribution in 1978. The two reasons most frequently cited in 1978 were the two most frequently cited in the current survey. A nuance in this regard was that those attributing their action to a predominance of secondary wage earners fell twelve percentage points to 26%. There is no immediate explanation for the fall. Small declines were also registered for employee turnovers and can't qualify for a group.

Given the reasons for not currently providing employee health insurance, stimulants to provide it were predictable. Lower rates and greater profitability were the two most frequently noted (Table 21). "Business got bigger," "qualify as a group," and "employees asked for it" followed at a distance. Just 4% of those not providing coverage for all full-time employees, or 3% of the entire sample, indicated they would not provide health insurance under almost any circumstance. That is about the same as the number providing the identical response in 1978.

Table 19

SMALL BUSINESS OWNER REASONS NOT TO PROVIDE HEALTH INSURANCE TO ALL FULL-TIME EMPLOYEES BY PERCENT OF FULL-TIME EMPLOYEES COVERED IN EACH FIRM

(in percent)

	PERCENT OF FULL-TIME EMPLOYEES COVERED IN EACH FIRM				
REASON	None+	1-39%	40-60%	61-99%	Total*
Premiums Too High	33	29	14	7	27%
Employee Turnover Too Great	15	21	18	8	15%
Generally Covered Under A Spouse or Parent Policy	26	29	33	26	29%
Never Thought About It	2	*	*	*	1%
Administrative Expenses Too High	8	5	2	1	6%
Employees Prefer Compensation	8	10	6	5	8%
Firm Insufficiently Profitable	20	10	11	2	15%
Can't Qualify For Group Policy	19	4	2	2	12%
Other	4	7	*	4	4%
Total@	135%	115%	86%	55%	117%
Number of Respondents	517	110	66	149	842

+ includes no answer
* less than 0.5%
@ respondents could mark more than one answer

Table 20

SMALL BUSINESS OWNER REASONS NOT TO PROVIDE HEALTH INSURANCE TO ALL FULL-TIME EMPLOYEES BY FIRM SIZE

(in percent)

REASON	FIRM SIZE (FULL-TIME EMPLOYEES)						
	1-4	5-9	10-19	20-49	50+	No Answer	Total*
Premiums Too High	32	32	30	21	11	14	27%
Employee Turnover Too Great	16	16	15	24	26	7	15%
Generally Covered Under A Spouse or Parent's Policy	33	32	40	23	14	11	29%
Never Thought About It	2	*	*	*	*	2	1%
Administrative Expenses Too High	7	6	5	3	6	4	6%
Employees Prefer Compensation	7	10	10	9	6	4	8%
Firm Insufficiently Profitable	20	12	9	6	9	13	15%
Can't Qualify For Group Policy	16	5	6	2	*	18	12%
Other	2	1	3	9	11	10	4%
Total@	135%	114%	118%	97%	83%	83%	117%
Number of Respondents	365	146	97	66	35	133	842

* less than 0.5%

@ respondents could mark more than one answer

Table 21

CAUSES FOR SMALL BUSINESS OWNERS TO PURCHASE HEALTH INSURANCE FOR ALL FULL-TIME EMPLOYEES BY PERCENT OF FULL-TIME EMPLOYEES COVERED IN EACH FIRM
(in percent)

	PERCENT OF FULL-TIME EMPLOYEES COVERED IN EACH FIRM				
CAUSE TO PURCHASE	None+	1-39%	40-60%	61-99%	Total*
Qualify as a Group	16	5	*	3	11%
Business Became More Profitable	24	23	11	4	23%
Rates Were Lower	36	23	17	9	28%
Minimum Coverage Requirements Dropped	5	5	2	1	4%
Rates and Coverages More Stable	8	5	3	2	6%
Business Got Bigger	19	11	6	3	14%
More Difficult to Find Good Employees	6	6	6	3	6%
Employees Asked For It	10	15	3	8	9%
Wouldn't Provide Under Almost Any Circumstance	5	3	2	1	4%
Total@	129%	96%	50%	34%	105%
Number of Respondents	690	105	32	44	871

+ includes no answer
* less than 0.5%
@ respondents could mark more than one answer

Concluding Observations

The survey did not (and probably could not) obtain data on the level of health insurance benefits provided. However, the evidence available suggests that benefits are surprisingly consistent or uniform given the varying conditions of the small businesses and small business owners surveyed. For example, almost all providing insurance carried hospitalization/surgical and major medical; virtually none provided lesser degrees. Similarly, virtually all had a dependent care option. While a broad distribution of monthly per employee costs was apparent, arguing against a uniformity thesis ("you get what you pay for"), the principal distinction seemed to occur between those employees covered and those employees not covered. Recall that no employees were offered health insurance in 36% of the firms and only selected employees were offered health insurance in 23% of firms. Given those conditions and the economic reasons many small employers gave for not offering health insurance, it is curious that the distribution of benefits is not much greater than it appears. This situation raises two related points. The first is whether the employer's decision to provide "all or nothing" coverage is purposeful or whether insurance pricing is structured to force a decision. The second is that public policy actions to include minimum coverage requirements serve to increase the gap between those covered and those not covered.

The dependence on outside advisors for health-related matters appears unusually high given the costs involved. Assuming these appearances are not deceiving, an entire series of questions then arise. For example, why is more responsibility delegated on health care to an "outsider" than it probably is on other purchasing decisions? Is it to the owner's and/or employees' benefit? What effect does it have on coverage patterns? This survey was not intended to answer such questions, but they are important ones that need to be addressed at some point.

There is no reason to expect a significant increase in the number of firms providing employee health insurance such as the one experienced between 1978 and 1985. However, some rise might be expected. On the plus side, reductions in health care cost increases should translate into more reasonable insurance costs (though they still are rising faster than inflation). A second plus is that trade associations show every sign of maintaining, if not increasing, their insurance-related activities. Association activity should continue to provide smaller and often less affluent firms access to group coverage. The third factor is that health insurance is increasingly accepted as a condition of employment; the market from this perspective is pushing greater direct coverage. But on the negative side, small business profitability was high in 1978 and reasonably high in 1985 (it peaked about a year and one-half earlier). It is doubtful similar favorable economic conditions can stimulate much broader coverage. Poorer conditions could do the opposite. In addition, there will always be differences in profitability, meaning there will always some firms with an affordability problem. Those negative reasons are on top of the employee related causes for not providing insurance. With the increasing use of part-time labor and secondary wage earners, the incentive to provide health insurance is declining; the market from this perspective is promoting less direct coverage. Thus, there are cross-currents which will influence small business owners' decisions on health care. On balance, these factors point to greater coverage, but not much greater.

POLICY RECOMMENDATIONS AND CONCERNS:

General

Based on the foregoing information and on our policy polls (Appendix A), the National Federation of Independent Business is opposed to any program of compulsory national health insurance, including one covering catastrophic illness only. The vast majority of Americans are protected by voluntary private insurance programs or already existing government programs. Furthermore, an increasing percentage of American firms are voluntarily providing substantial health insurance benefits to their employees. The need for such an intrusive policy on the part of the federal government seems to be minimal; indeed, this seems to have been generally accepted lately, since the public policy debate is no longer focused on broad mandatory national requirements but rather on trying to address the specific problems of limited portions of the population, e.g., those with existing medical problems, self-employed, children, unemployed persons, and others desirous of being insured but unable to afford it. This has been a generally positive turn of events and one which NFIB finds encouraging. However, in the attempt to target policy to such groups Congress and the states must be careful not to create new gaps by discouraging (because of mandated cost increases or unrealistic administrative demands) the increase in voluntary employer sponsorship of health plans. In short, we are happy to assist this committee, or anyone else, with information about the characteristics of small firms in this country which might assist in a market oriented solution to closing the health insurance coverage gap.

While an increasing percentage of small business owners provide employee health insurance, it would be unrealistic to expect, and unwise in the extreme to mandate, 100% coverage of all small business employees in the country. There are too many factors which neither the government nor the small business owner can control which mitigate against such an expectation or such a mandate. Such things as high employee turnover, the large percentage of secondary wage earners working for small businesses, and the variable profitability of firms are all beyond the control of reasonable policy. Nevertheless, some of the reasons currently given for non-coverage may be amenable to policy changes. That the firm can't qualify for a group policy or that premiums are too high may bear investigation. Let me first consider the limiting conditions.

Employee turnover in small businesses is high, although layoffs appear relatively low except in the construction industry. This is the result of numerous factors, including heavy utilization of teenagers, seasonal help, generally lower wage scales, etc. In fact, the NFIB Quarterly Economic Report for Small Business consistently finds approximately one in ten small firms has a net decrease in employment every quarter, with an average of three to four employees per firm. While these data do not capture the extent of turnover because they measure only decreases among firms registering net decreases in total employment, they are indicative of the situation. Corroborative indications of high employee turnover can be found in two additional pieces of data: 1) 38% of all small employers register as a common complaint about job applicants that they will not stay long; and, 2) 15% of those small firms not carrying employee health insurance indicate high employee turnover as a reason for not doing so.

Secondary wage earners are a very large portion of the small business labor force. NFIB estimates that 80% of all teenagers working are now employed by small firms. While all teenagers are not secondary wage earners, they are far more frequently secondary wage earners than adults. *In all size categories of businesses, the single biggest reason for not providing health insurance to all employees was that their employee mix consisted of significant numbers of people generally covered under a spouse's or parent's policy*.

Profitability is a problem for every business entity, but particularly so for the very smallest firms, which are often start-ups. There are large numbers of marginal small businesses that simply cannot afford to increase fixed costs by offering health insurance benefits to employees. We find that the median money income of self employed persons is lower than the median money income for the population as a whole. The assumption, therefore, that *all* firms are capable of taking on such an additional fixed cost simply isn't valid. Looking back to tables number 2 and number 20, in the size categories 1 to 4 and 5 to 9, I believe demonstrates this point quite vividly. It is in these size categories where lack of profitability is a significant reason for not offering health insurance, and they are also where we see the largest gap in coverage.

The above three factors taken together must obviously limit one's expectations about the ability of small firms to provide health insurance for employees. They also are limitations to federal or state policy in this area. The following are some of those policy limits:

> First, *a period of employer paid insurance benefits beyond job termination is unreasonable*. It is conceivable, under some of the proposals I have seen, that a small employer could pay for an employee's insurance for more than twice the number of days that individual was employed (e.g., assume insurance eligibility after one month's employment and coverage termination three months after separation). This situation opens the door to all kinds of abuse and serves as an incentive for movement in and out of the labor force. More importantly, however, it would generate considerable paperwork and unnecessary premium payments. For example, if a separated employee immediately accepted another job unbeknownst to the original employer, both employers could be paying premiums on the same individual. Furthermore, those employers without computerized payroll systems, i.e. most small employers, would find themselves filing and re-filing with their insurance companies as well as rearranging their bookkeeping procedures to ensure that a separated employee is removed from the covered list as soon as legal.
>
> Second, *any program that required coverage for seasonal employees* -- those that are hired for a specified period of time, like the Christmas season or for the summer -- *would be a mistake*. In such short term employment situations it is recognized by both parties that the employment is temporary and not necessarily

> subject to the identical pay or benefit conditions of those employed full time. If such employees were required to be covered by statute, the incentive would be for employer to reduce the number of jobs for teenagers, particularly, by having existing employees work overtime, or by developing some "three weeks working and one week not working" mechanism to avoid the system, or by doing without -- none of which would be beneficial to the employees or the employers.

Third, unless consideration is given to the problem of double coverage (beyond that already cited) resulting from the large proportion of secondary wage earners in the small business labor force, any nationally mandated program would be terribly wasteful and unnecessarily expensive. For example, a small employer could be required to pay for insurance on a teenage employee while that teenager's father's employer could also be paying premiums for that teenager. To further illustrate this point, the following example is provided*:

Small businessman Jones owns and operates a nursery. Mr. Smith works for Mr. Jones and is covered by health insurance. During the spring and summer, business always picks up, so Mr. Jones hires four teenagers, including Mr. Smith's two sons. Two of the teenagers begin work May 15, and the Smith boys start June 1 and June 7. On June 15, small businessman Jones begins to pay insurance premiums on the first two teenagers hired (neither they nor Mr. Jones knows they are already covered under their parent's plans), but on June 20 one of them quits, to be followed by the second four days later. Two more teenagers (also unknowingly covered by their parent's plans) are hired June 25 and July 4th. The Smith boys leave the job to return to school on August 24 and September 1. The other teenagers leave September 14th, but one of the two drops out of school in a week and takes a full time job. Here is the result of summer employment for small businessman Jones:

--about 15 months of work
--nearly 30 months premiums paid
--no additional coverage secured for any employee
--considerable paperwork

Cost are not estimated here because it makes a considerable difference whether or not Mr. Jones's business is large enough to qualify as a group. This brings me to the problems cited by small business owners which originate from the product, or seller's, side of the market.

---

* This example assumes required coverage one month after employment through three months after job determination.

The two biggest reasons cited by small employers for non-coverage in this regard were that *premiums are too high* (overall this was the second most important reason for non-coverage) and that the firm *could not qualify for a group policy*. The one thing most often cited by small firms, especially the smallest, that would induce them to offer health insurance for all their full time employees was lower premium rates. It should be noted our data show that small businesses in the aggregate have had their premium costs doubled in the last eight years. In some industries, like transportation and the professional services, these costs have tripled in the last eight years. Part of the reason small employers face such large health insurance costs is that more than two-thirds of them paid the entire premium cost for their employees, and 87% of them paid more than half.

In addition, it is the smaller firms which pay a greater proportion of the premiums themselves.

The point for policy makers here is, however, that if they wish to increase the percentage of small business employees who are voluntary covered by health insurance plans, including health insurance, they should look to the health care industry and the insurance industry to ensure that the market is operating to provide the lowest prices. That is, to insure the market is operating efficiently and *competitively*. Not being an expert in either the health care industry or the insurance industry and having no policy guidance in this regard from my members, I will leave that judgment to others for the moment. I will note only that the cost of insurance, all types of insurance, has emerged as the number one problem of small businesses in this country.

The percentage of small employers that do not have any employee health insurance and who claim that they do not do so because they cannot qualify as a group has declined since 1978 from 25% to 12% in the aggregate. We attribute this drop to the fact that trade associations are increasingly acting as group sponsors. NFIB, for example, has recently became a group sponsor offering employee benefit packages to our members. While we expect this trend to continue and to improve the coverage problem, it is perhaps another area for policymakers to investigate. It may be feasible for the government to operate as a market maker in this area. While the inability to qualify as a group has declined, it still remains one of the major barriers to offering health insurance plans for small employers. NFIB is not advocating government involvement in this area, since we expect trade associations to increase their activities in offering group plans. It is, however, an aspect of the overall problem which may more easily lend itself to government involvement than would other aspects of the problem.

S. 2403, ACCESS TO HEALTH CARE ACT OF 1986.

To a considerable, and encouraging, degree S. 2403 is sensitive to the general concerns and recommendations that I have previously outlined. If only in that it apparently exempts those employers with fewer than 20 employees. But further than this, its approach does seem to be toward correcting market deficiencies and toward consumer choice. As you have noted elsewhere 5 or 6 years ago the proposals before Congress were considerably more intrusive and overbearing, in that they, almost universally, contemplated some form of federally administered national health insurance or nationally mandated all-payer insurance systems. As such, they were relatively easy for the small business community to react to -- they opposed them one and all. With the shift in the focus of the debate it is somewhat more difficult to be so unequivocable in our response. Having said that let me proceed, section by section, to the concerns for small businesses that I see in S. 2403.

Section II, Incentives for the Establishment of State Wide Insurance Pools:

I find nothing in our survey material or in our policy polls which would lead me to believe that our members either oppose such a program or would be adversely affected by it - at least, to the extend that any such program did not increase their existing employee health insurance premiums. I will note, however, that since the uncovered employees of small businesses would qualify for such a program and since small employers are increasingly able to qualify for group policies because of increased trade association sponsorship of them, that for this sector of the population the need for such a program is declining. I suspect, however, that your primary target group here is those people with existing medical conditions and not the uncovered employees of small firms.

I would add three comments on the language of this section:

1. Your definition of a large employer is not so generous as it at first appears. While it seems to preclude seasonal employees from coverage, it specifically includes part-time employees. Nearly 25% of all small business employees are part-time employees. And some industries, such as agriculture, retailing, professional services, and the hospitality industry, generally, rely particularly heavily upon part-time employees. In these industries an employer with significantly less than 20 full-time employees could find himself defined as a large employer. I would recommend re-working the definition so that it applied to those employers with 20 or more full time employees.

2. This is actually in the nature of a question. In the section defining "qualified pooling associations" where pool premium rates are discussed, will it not be the case that by capping pool premium rates to no more than 150% of average premium rates for individual standard risk in the state for comparable coverage you are ensuring that the pool will realize losses that

The participating members will have to make good? Since it is high risk individuals who are likely to select this insurance, is it not likely that it will be expensive to run such a pool?

It is also unclear to me how the payment of losses would be apportioned. The language says "equitably", but in this context that seems to me insufficiently clear.

3. It appears blatantly unfair to impose a 10% excise tax on "large employers" for the failure of state legislators, for whatever reasons they might have, to pass the necessary state implementing legislation to establish state wide insurance pools. The excise tax should come into effect only if a state creates such a pool and the "large employer" choses not to be a member.

Section III, Requiring State Programs for the Uninsured and Underinsured:

This section is beyond our expertise to comment on, other than to say, that if any state attempts to meet the requirements of this section by mandating increased payroll taxes or other labor based taxes, I would expect the small employers of that state to oppose it.

Section IV, Temporary Extension of Coverage for Laid Off Workers; Open Enrollment for Spouses of Unemployed Workers:

For all of the reasons cited in the previous section of this testimony we oppose the requirement for 4 months of employer paid health insurance beyond job termination (or reduction in hours). The realities of the labor market facing small employers are too stark not to expect a provision like this to have detrimental effects on employment, plan sponsorship, employer payment patterns (now, small firms, more often than not, pay 100% of premiums) or the survivability of many small firms. I will not re-argue the case made on pages 25 to 27, I will only add that the paperwork, alone, involved in notification and recordkeeping would be an overwhelming nightmare for the vast majority of small businesses.

If the committee insists on such a provision, I would make two recommendations:

First, that a specific and simple mechanism be included to eliminate the possibility of double coverage by different employers.

Second, that in the section of the Code giving as one of the qualifying events "termination of the covered employees employment (other than by reason of such employee's gross misconduct)" that "or quitting" be included. Such recommendations may help solve part of the problem, but they will increase, unfortunately, another - paperwork.

Other than its potential upward pressure on premium rates, I find no reason in our survey material or in our policy polling to oppose the open enrollment for spouses of unemployed workers. On the surface it appears like a good and humane idea.

Section V, Deduction Allowable for Certain Group Health Plan Contribution by Self Employed Individuals:

NFIB supports this provision and has supported its general thrust for a long time. We have done so as much based on the equity to the self employed individual as for its incentive effect on increased employee coverage. We consequently support the similar provision contained in the tax reform bill.

Section VI, Demonstration Projects on Improving Access to Health Insurance for Small Employers and Self Employed Individuals:

We, of course, heartily support this section, urge it be given a high priority, and volunteer to provide whatever assistance and resources we can to its successful completion.

APPENDIX A

MANDATE QUESTIONS ON HEALTH INSURANCE

DESCRIPTION	MANDATE #	DATE	FOR	AGAINST	UNDECIDED
Do you favor a mandatory national health insurance program? a) yes; b) yes, but catastrophic only; c) no; d) undecided?	400 (1)	12/76	a) 10% d) 3%	b) 34%	c)53%
If everyone were covered by a system of mandatory national health insurance, what benefits should be available? a) comprehensive; b) deductible; c) catastrophic only; d) undecided?	400 (2)	12/76	a) 6% d) 8%	b) 19%	c)67%
If a system of mandatory national health insurance were established, how should it be financed? a) general taxes; b) payroll deductions; c) premiums; d) undecided?	400 (3)	12/76	a) 24% d) 12%	b) 14%	c)50%
If a system of mandatory national health insurance were established, who should administer it? a) federal government; b) state government; c) private insurance companies; d) undecided?	400 (4)	12/76	a) 10% d) 12%	b) 10%	c)68%
Should employers be required to provide a minimum level of private health insurance for their employees? a) yes, and pay the entire premium; b) yes, and pay part of the premium; c) no; d) undecided?	400 (5)	12/76	a) 4% d) 5%	b) 19%	c)72%
A program of national health insurance to cover catastrophic illness only?	415 (3)	1/79	39%	55%	6%
The Medical Expense Protection Act?	426 (4)	4/80	14%	79%	7%

DESCRIPTION	MANDATE #	DATE	FOR	AGAINST	UNDECIDED
Taxing--as income to employees--employer-paid health-insurance premiums in excess of $175 per family, per month?	448 (2)	4/83	25%	72%	3%
Limiting the deductions for health insurance for employers?	451 (2)	11/83	26%	69%	5%
Taxing employees on fringe benefits?	459 (2)	4/85	24%	72%	2%
Allowing states to require certain types of coverage in employer-sponsored health plans?	462 (4)	12/85	9%	89%	2%

APPENDIX B

SURVEY SAMPLE

The preceding report was based on data gathered from a mail survey of small business owners conducted in September, 1985. The survey sample was randomly drawn from the membership file of the National Federation of Independent Business (NFIB). All regular members in the file were eligible for selection, the exception being a comparatively small percentage who had no full-time employees. Thus, the resulting sample consisted entirely of small employers. Each of the 7,750 small business owners in the sample received a questionnaire (a copy provided in Questionnaire, p. 46) and a follow-up two weeks later. There were 1,439 usable responses for a 19% response rate, 11 percentage points less than NFIB normally experiences in such surveys.

There is little a priori reason to fear a sample bias. Dunkelberg and Scott have demonstrated that the NFIB membership file reasonably reflects the universe as the universe can best be estimated. Moreover, the sample was not contaminated by association activities involving extensive sale or promotion of employee benefit packages. And while response rates of 30%, let alone 19%, never can provide a survey analyst comfort, previous experience in comparing NFIB-collected responses to equivalent data collected by other organizations shows remarkable consistency, particularly within size class. The differences that do exist usually involve "levels" for the entire population resulting from the somewhat larger businesses within the NFIB file.

Tables A and B provide comparisons of the estimated universe, the survey sample, and the survey respondents. (The estimated universe measures were drawn from the Small Business Administration's (SBA) Small Business Data Base as published in the annual The State of Small Business Report.) Note on Table A that the industry-by-industry differences in these data sets are minimal. Survey respondents are somewhat overrepresented among manufacturers and underrepresented among services. In the other major industries, however, differences usually involve only a percentage point or two.

When employee size is substituted for industry in the three set comparison (Table B), the result is not as satisfactory. The profile of survey respondents and the survey sample are virtually identical, with the exception of 1-4 employee class size and "no answer." Distributing the no answers proportionally among all size classes creates a survey respondent profile still somewhat underrepresented in the 1-4 employee class and a percentage point or two overrepresented in the others. That distribution in and of itself should be sufficient to cover all concerns over the response rate. However, the responses of "no answers" and the responses of other size classes to other comparable questions produce an uncommon similarity between the "no answers" and the 1-4 employee size class. Given that similarity and previous experience which indicates the smallest are most likely not to respond to size questions, responses proportionally allocating "no answers" probably do not assign enough to the smallest size class. As a result, the profile of survey respondents and the survey sample is probably even better than the considerable similarity previously shown.

Table A

COMPARISON OF ESTIMATED UNIVERSE, SURVEY SAMPLE, AND SURVEY RESPONSES BY INDUSTRY
(in percent)

INDUSTRY	ESTIMATED UNIVERSE	SURVEY SAMPLE	SURVEY RESPONDENTS
Construction	14	11	12
Manufacturing (includes Mining)	9	13	13
Transportation	4	3	4
Wholesale	10	7	10
Retail	29	27	27
Agriculture	4	5	5
Financial Services	8	7	9
Services	24	24	19
No Answer	--	2	1
Total	100%	100%	100%

While the estimated universe inflates the 1-4 employee size class a percentage point or two by inclusion of some non-employers, there remains a difference between the estimated universe and the sample. Sample small business owners (as well as respondents) have somewhat larger businesses on balance. The estimated universe contains approximately 10 percentage points more firms in the 1-4 employee size class than did the sample on the response. Those 10 percentage points were distributed over other size classes. Thus, population "levels" are unduly influenced, though not greatly, by owners of firms larger than 1-4 employees.

Table B

COMPARISON OF ESTIMATED UNIVERSE, SURVEY SAMPLE, AND SURVEY RESPONSES BY EMPLOYEE SIZE
(in percent)

EMPLOYEE SIZE	ESTIMATED UNIVERSE	SURVEY SAMPLE	SURVEY RESPONDENTS
1-4	57	48	37
5-9	21	21	21
10-19	11	15	15
20-49	7	11	10
50-99	2	3	4
100 or more	2	2	3
No answer	--	1	11
Total	100%	100%	100%

Prepared Statement of Patrick F. Killeen

Mr. Chairman, I am Patrick F. Killeen, Assistant Director and Senior Health Care Consultant for the Social Security Department of the International Union, United Automobile, Aerospace & Agricultural Implement Workers of America (UAW). The UAW appreciates the opportunity to testify before this Subcommittee concerning the proposed "Access to Health Care Act of 1986" (S. 2403, S. 2402). I appear on behalf of 1.5 million active and retired UAW members, including many thousands of UAW members who have lost their health insurance coverage due to unemployment. We commend this Subcommittee for addressing the unmet health care needs of uninsured individuals, one of the most serious problems we face as a nation.

The UAW is firmly committed to the principle that all individuals should have access to adequate health care as a basic human right. Unfortunately, this right is not a reality for many Americans.

The extent and seriousness of the lack of health insurance is well known. The Bureau of Labor Statistics estimates that one-third of laid off workers have no health insurance coverage of any kind. This translates into millions of people, including more than 200,000 displaced members of our Union, who have lost essential family health protection as a result of layoffs.[1] The impact of job loss on health insurance coverage is usually immediate. According to a Department of Labor study, close to 60 percent of workers lose their health protection immediately or within a month of layoff, and only 20 percent have protection beyond three months.[2] A recent University of Michigan study shows that in the Detroit area 51 percent of unemployed individuals were without health insurance. Of this group, 78 percent lost insurance as a direct result of having lost their jobs.[3] Those workers who are lucky enough to get new jobs often have to wait months for coverage that is substantially poorer in benefits than their previous coverage. The dimensions of this problem become enormous when one considers that approximately 21.5 million people, nearly 17 percent of the population, will be without work for all or part of the year.[4]

Of all the industrialized nations, only in South Africa and the United States, which have no national health plans, is the tragedy of unemployment compounded by the fear and insecurity caused by loss of family health care protection. The limited budget of the unemployed is seriously strained by competing essential priorities. Mortgage or rent payments, threatened utility cut-offs, merely putting food on the table, are the harsh everyday realities. There is no money for health insurance. As a result, receipt of necessary medical treatment is often ignored or delayed with sometimes serious consequences. A study of laid off auto workers in Michigan by the Social Welfare Research Institute indicates that 17 percent of laid off workers do not even try to seek needed care.[5] This is a shocking situation.

Looking beyond the difficulties of those laid off, we find a problem even more staggering. The number of Americans without any public or private health insurance is now 35 million people.[6] When those who lose insurance protection for short periods of time are included, the total is well over 50 million people.[7] A recent study by the Robert Wood Johnson Foundation found that one million Americans are refused medical care annually because they cannot pay for it; another five million do not even seek care they feel they need because they know they cannot afford it.[8]

Many of the problems we currently face in providing health care for the uninsured have been aggravated by the increasing corporatization of medicine and the Reagan Administration's approach of promoting growth of the for-profit sector in health care. Previously, public hospitals and not-for-profit community hospitals provided care for the uninsured by subsidizing that care through charges made to insured third-party payers. However, the growth of for-profit hospital chains has severely reduced these types of social subsidies for the poor and uninsured. Because of heightened competition in the health care industry, the not-for-profit community hospitals have increasingly been financially unable to continue to provide care for those without adequate health insurance.

Future forcasts call for more of the same. According to Dr. Arnold Relman, Editor of the New England Journal of Medicine, and a leading critic of for-profit health care entrepreneurs, as many as 180 public hospitals were purchased or came under the management of for-profit hospital chains between 1970 and 1980. He also warns that 30 percent of all hospitals will be chain-owned by 1990 if the current rate of expansion continues.[9] The American College of Hospital Administration makes an even more alarming prediction, estimating that by 1990, chains will own 60 percent of U. S. hospitals.[10] This will result in less and less health care being made available to the poor and uninsured, thereby increasing the financial burden on already desperately strapped individuals and nonprofit and public hospitals.

Recognition of the serious plight of the uninsured has spawned a number of voluntary efforts on the part of community leaders, labor unions, hospitals and physician groups around the country to provide some health care services for the uninsured. Several states have also established subsidized insurance pools for those without access to employment based health insurance. Others have established systems to fund hospital care for the uninsured. Although such efforts are commendable, they fall far short of what is needed and many problems remain. These efforts are geographically scattered and uncoordinated; they do not address much of the known need; and they often fail to provide adequate financial support to pay for health care services for those least able to afford it -- the poor and the unemployed -- leaving this financial burden on the already severely burdened public and nonprofit community hospitals.

The Medicaid program also fails to provide adequate access to health care for the unemployed and uninsured. Although Medicaid provides health care coverage to the poor, because of stringent eligibility criteria it does not cover many unemployed and uninsured persons. According to the University of Michigan study, only 25 percent of the unemployed had Medicaid coverage for either themselves or for their children.[3] This problem has been exacerbated by cut-backs in Medicaid promoted by the Reagan Administration. Many unemployed persons are also ineligible for Medicaid because they are first required to deplete assets acquired while they were employed. The UAW submits that no one should be required to become impoverished in order to be able to get access to adequate health care services.

The UAW believes that only the ultimate passage of a comprehensive national health security program will adequately remove the barriers to access to health care for the millions of unemployed and uninsured individuals in this country. We continue to find widespread support for a national health program around the country.

In the short term, there is an urgent need for federal legislation to improve access to health care for the unemployed and the uninsured. The UAW commends the Chairman of this Subcommittee, Senator Durenberger and the Ranking Member of the Labor Committee, Senator Kennedy, for introducing the the proposed "Access to Health Care Act of 1986" (S. 2403, S. 2402). We believe that this legislation would represent an important first step in meeting the unmet health care needs of millions of persons in this country. We urge the Subcommittee to give this legislation prompt, favorable consideration.

The UAW is particularly pleased that Access to Health Care initiative would begin to help alleviate some of the problems faced by laid off workers and their families in obtaining access to health care. Most importantly, S. 2403 and S. 2402 would require employers to continue health care coverage for at least four months after workers are laid off. Employers would be required to continue whatever level of coverage and employer contributions were previously offered to active workers. This would help to bridge the gap in health care coverage for a large segment of the unemployed.

Some large corporations already continue health insurance coverage for laid off workers. For example, under major UAW contracts, health insurance coverage for laid off workers may continue for up to two years, depending on length of seniority. But these contractual benefits are not typical for most workers, nor for many members of our Union in independent parts and supplier plants, who often lose health insurance coverage at the point of layoff.

This provision in S. 2403 and S. 2402 builds upon the health care continuation provisions contained in the Consolidated Omnibus Budget Reconciliation Act, which requires employers to allow laid off workers to continue, at their own expense, coverage under their employer's group health plan for up to 18 months. In addition, widows and widowers, divorced spouses, spouses not yet eligible for Medicare and dependent children have the right to continue coverage under the employer's group health care plan for up to 36 months, again at their own expense. While these provisions are helpful and a step in the right direction, they do not solve the problem faced by the unemployed in obtaining access to health insurance coverage. This cost is simply prohibitive for most unemployed persons, given their already strained family budgets. Indeed, prior to the passage of the group health care continuation provisions in the budget reconciliation measure, only about one percent of the persons in Michigan who lost coverage under their employer's group health care plan elected to convert to individual policies, which typically cost less than group policies because they offer substantially fewer benefits.[11] Accordingly, it is apparent that very few laid off workers will actually be able to afford to exercise their option to continue coverage under the employer's group health care plan, which usually is even more expensive. To make health care coverage affordable for laid-off workers, government or employer contributions are critical.

In 1983, the House passed legislation to provide health care for the unemployed (H.R. 3521). This bill, which was supported by the UAW, would have required employers to continue health care coverage for laid-off workers and also would have authorized funds for a federal program to provide health care for the long-term unemployed. Unfortunately the Senate rejected efforts to provide federal funds for this purpose; however, it never took up the issue of requiring employers to continue insurance coverage.

The health care initiative introduced by Senators Durenberger and Kennedy would not create a new federal program. Instead, it simply embraces the concept that employers should be required to continue health care coverage for laid off workers for a period of time. Although the UAW believes that any solution to the problem of health care for the unemployed necessitates some federal program, the private sector initiative contained in the Durenberger-Kennedy bill would still make an important contribution towards providing improved access to health care for the unemployed.

The health care continuation provisions in S. 2403 and S. 2402 will actually help to reduce federal and state expenditures. When employers fail to continue health care coverage for laid off workers, the costs of providing coverage do not disappear. To the extent that care is provided, much of these costs are simply shifted onto other payors -- either the federal and state governments under Medicaid, or onto the public and non-profit community hospitals who handle most charity care. Requiring employers to continue health care coverage for laid off workers will reduce this cost shifting, and thus will actually reduce Medicaid expenditures by the federal and state governments (as well as relieving the burden on public and non-profit community hospitals).

Requiring employers to continue health care coverage for laid off workers will not impose an undue burden on businesses. In most cases, these additional costs will represent only a small fraction of the overall health care expenditures by the employer. And employers always will have the option of pre-funding these liabilities, so that they are prepared for economic downturns.

The UAW would also like to comment briefly on the other sections of the Access to Health Care initiative. S. 2403 and S. 2402 also would give the spouses of workers who lose their jobs the right to enroll in the health care plan offered by the spouse's employer. All too often, whole families lose essential health protection because the spouse with family health care benefits loses his/her job, and the other spouse is precluded from enrolling in his/her employer's health care plan. S. 2403 and S. 2402 would effectively solve this problem by creating an automatic enrollment window period for the still employed spouse.

The UAW also believes that the provisions requiring the states to establish a system to fund hospital care for the uninsured and the poor are commendable. The need for such state systems has been made even more intense by the increased competition between health care providers, who are compelled to offer less and less care to the poor and the uninsured because of reduced subsidies for such care from Medicare and other third-party payers. Moreover, the establishment of state systems to fund hospital care for the uninsured and the poor would help to alleviate the strain that uncompensated care currently places on public and non-profit community hospitals, whose survival is becoming increasingly threatened. Many of these hospitals are in areas of high unemployment or in rural areas, where they are the providers of last resort for a growing number of individuals.

The UAW urges the Subcommittee to give careful consideration to certain details of this proposal. For example, federal standards need to be included to insure that such systems do not exclude significant numbers of the needy through too stringent eligibility standards or through the use of copayments. Similarly, the level of benefits available under such systems needs to be spelled out in more detail, as well as the provisions dealing with patient ability to pay. The legislation also leaves the states considerable discretion as to the type of funding mechanism which can be utilized. The UAW believes that health care providers, health insurers, and the federal and state governments all should participate in any financing mechanism, in order to assure a complete and successful response to the problem of uncompensated care. We are also concerned that the penalty which would be imposed on states that fail to establish an appropriate system -- eliminating federal funds for the administration of the state's Medicaid program or for the state's Public Health Service Act programs -- could have an adverse impact on health care for the elderly. We urge the Subcommittee to explore other possible penalties, such as denying tax-exempt bonds for hospital construction and equipment acquisition unless there is an appropriate state system to handle uncompensated care.

The UAW also supports the provisions dealing with the creation of subsidized state insurance pools for the "uninsurable". Through such mechanisms, the states can guarantee the availability of health insurance to individuals, regardless of their health status. Currently, there are many individuals who do not have access to employment-based health insurance who cannot obtain private insurance on their own because of pre-existing medical conditions. This proposal would assure that these individuals have access to health insurance at affordable rates. However, we believe that some of the details of this proposal require additional consideration. In particular, we believe that *all* employers ought to be required to participate in and help share the costs of these state pools, not simply employers that currently offer insured or self-insured health care plans. Otherwise, the states will be in the position of rewarding those employers who choose not to offer any health care coverage to their employees.

In conclusion, the UAW would again like to commend Senators Durenberger and Kennedy for introducing the Access to Health Care Initiative. We believe that this package of proposals represents an important first step towards meeting the urgent problem of providing adequate access to health care for millions of uninsured persons in this country. The UAW looks forward to working with the Members of the Subcommittee as it considers this important legislation. Thank you.

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Prepared Statement of John P. Papp, M.D.

Mr. Chairman and Members of the Subcommittee, the American College of Gastroenterology commends you for holding these important hearings and for your strong efforts to rectify a crisis faced by so many Americans today. Inaccessibility to health care is indeed a national crisis. As you well know, we are not talking here about access to quality health care - we are talking about access to any health care. Today, 37 million Americans have no health insurance. In most cases, they have no health insurance either because they cannot afford the high premiums or because they have a pre-existing condition which prevents them from being able to obtain health insurance. Not only does this pose a devastating financial problem for many Americans, but it has been estimated that approximately one million Americans are refused medical treatment because they cannot afford to pay for it.

The American College of Gastroenterology considers the Access to Health Care Act of 1986 a critical step towards assuring the availability of health insurance to all Americans, particularly those most in need of coverage. The legislation's provisions to strengthen employment-based health insurance pools, establish subsidized health insurance pools, and develop a mechanism for state funding of hospital charity and unreimbursed care provide a viable solution to this national crisis.

The American College of Gastroenterology strongly supports the Access to Health Care Act of 1986 and commends Chairman Durenberger and the co-sponsors of this legislation for their strong leadership and firm commitment to alleviating the devastating problem of inaccessible health insurance.

June 23, 1986 Statement of Steve Judd

George Kehoe

RE: HEALTH CARE IMPROVED ACCESS ACT OF 1986, H.R. 4742 ("KENNEDY/STARK" BILL)

George, thanks for the opportunity to comment on this bill. As you know, I am currently serving as a member of the Board of Directors of the Minnesota Comprehensive Health Association (MCHA) and as Chairman of the Actuarial Committee of the MCHA. I also served on the Writing Carrier Contract Committee this past year. In these capacities, I have had the opportunity to see how this health insurance pool for uninsurables works in Minnesota. In addition, Federated as an insurance company member, has participated and has been assessed and paid its share of the net losses in such pools in Indiana, North Dakota, Nebraska and other states.

Based on our experience from these involvements, we believe that statement issued by the Health Insurance Association of America by H. Michael Schiffer before the Health Subcommittee of the Committee On Ways And Means on June 9, 1986 is a good representation of the issues involved concerning this bill. We agree with the conclusion of the HIAA that "the risk-pool provision of the Stark/Gradison and Kennelly bills will ensure the availability of health insurance for all Americans, regardless of the condition of their health, with an absolute minimum of Federal regulation, and at no cost to the Federal treasury". We are pleased that the Health Insurance Association of America has indicated its willingness to assist in securing enactment in Congress of this important health care measure.

With respect to the other major sections of the Health Care Improved Access Act, we share the concerns expressed by the HIAA and would encourage the continued study and discussion of these provisions before they are enacted.

Steve Judd

Steve Judd, Member
American Academy of Actuaries
jh

STATEMENT OF
SELF INSURANCE INSTITUTE OF AMERICA, INC.
ON
"THE ACCESS TO HEALTH CARE ACT OF 1986"
(S. 2403)

This statement is submitted on behalf of the Self Insurance Institute of America, Inc. ("SIIA"), a national association of over 600 members including employers, third-party administrators, reinsurance companies and other interested parties dedicated to the improvement of the self-insurance industry.

SIIA appreciates the opportunity to express its views on S. 2403, "The Access to Health Care Act of 1986", which would, among other things, require that employer sponsored group health plans provide health insurance benefits for four months for employees who are laid off and their dependents.

In brief, SIIA supports the present system of voluntary, employer sponsored health plans which provide benefits to millions of employees. These plans are tailored to meet the varying needs of employers and employees in accordance with the unique requirements of the employer-employee relationship. SIIA opposes federal controls which would mandate special coverages because they would increase already spiralling private sector health costs and limit flexibility in plan design. Such action will impact adversely on the private voluntary system and will create less rather than greater coverage. Indeed such legislation would be particularly burdensome for smaller employers who may have to lower wages or eliminate group coverage altogether.

Federal Mandates Will Reduce Coverage

For over 50 years employers have taken the initiative on a voluntary basis to provide employer sponsored, and in many cases, employer paid health benefits to their employees. Recently, the President signed into law legislation which mandated that employer sponsored group health plans, whether insured or self-insured, must allow previously covered spouses and dependents of former employees to elect to continue health coverage. On the heels of this new law, Congress is now considering yet another Federal law, S. 2403, which would intrude once again into the private health care system by mandating that additional benefits be provided under private plans.

This law requires, among other things, four months of employer paid health benefits for laid off workers. This latest mandate will make it even less attractive for employers, particularly small employers, to continue to provide employer sponsored health benefit programs. In short, as the Federal government continues to mandate the inclusion of health care benefits, we are concerned there will be a deterioration of this voluntary system and employers will elect to discontinue providing employer sponsored (paid) health care coverage. Thus, we submit that S. 2403 is not in the best interest of employees, dependents of employees, employers, providers of health care, and the general population.

Private Voluntary Health Care System Works Effectively

The vast majority of our population is in fact covered by some form of health care, whether provided through private group funding arrangements or through the Government. Private sector plans are designed to meet the specific needs and financial resources of employers and employees. Employers now spend an estimated $100 billion each year on health care for their employees. As employer sponsored health care plans have multiplied, basic medical coverages have expanded, and new programs have been added to cover medical expenses beyond the traditional exposures. For example, dental protection as well as other forms of health care protection such as vision care, long term and short term disability are now provided under many employer sponsored health care programs. Moreover, ERISA gave employers an opportunity to provide uniform benefit plans without state government interference when they elect to self fund the benefits rather than use the services of a commercial insurer. ERISA's broad Federal preemption provisions, which preclude state regulation of welfare benefits plans, implicitly reflects Congress' rejection of minimum standards for such plans, including coverage. This private system is working well and should not be burdened with costly new requirements which would inhibit its continued growth.

S. 2403 will erode the concept of voluntary employer sponsored programs. Although the concern of government to expand the availability of health insurance to those who are not presently covered is understandable, we do not believe the answer to this problem lies in mandating the inclusion of such coverage in private plans. In effect, S. 2403 seeks to establish a form of national health care, by shifting costs to employers rather than to the public.

Reasons For Rejecting New Federal Mandate

S. 2403 should be rejected for the following reasons:

1. It places new burdens on the free enterprise system which will result in increased costs to employers. The cost to provide and fund benefits for the uninsured will be passed on to the employer in the form of: (a) increased administrative cost; (b) poor plan experience causing increased cost to all participants; and (c) adverse selection against the plans.

2. It would favor interest groups especially those who represent the provider sector of the health care industry. For the past several years, health care costs have continued to rise and treatment of conditions in many situations may have gone far beyond what is required. Providers have long capitalized on funding their services through group health care arrangements. The medicare program is living proof of what a blank check can do to any provider. This will surely exacerbate the problem of rising costs.

3. It mandates that employers must continue their group health plan for employees who terminate regardless of the reason for termination and their dependents. Employer sponsored plans are designed to cover the active work force, not those who elect

to leave the company or are laid off. In fact most group plans already contain provisions for such occurrences and in many cases provide the right to convert to individual plans. However, such rights are not granted regardless of the reasons for termination. To mandate that employers must continue coverage for employees who terminate and, at the cost of the employer, will undermine the employer-employee relationship and will create a further incentive for many employers to drop their employer sponsored benefit plans. Should this occur, an even greater "uninsured" problem will be created.

4. The provision for a special open enrollment would have a devastating effect on group plans. S. 2403 provides the opportunity for employed spouses of laid off workers to "select" against the group plan which will result in higher benefits, resulting in adverse experience requiring substantial rate adjustment to the employer sponsored plan. This is unfair cost shifting.

5. S. 2403 also requires all states to establish "pools" to cover all people who do not have health insurance, even if they elected not to purchase coverage on their own. Yet, many states already have in place some form of social aid and state residents as well as business are already helping to fund these state programs. S. 2403 will only serve to complicate matters and make "health care abuse" an even more attractive activity than it already is.

On the positive side, S. 2403 would create a new incentive for small business to provide benefits to all employees as well as the owners of sole proprietorships, partnerships and sub-chapter corporations. Under this provision, employers will be able to deduct their personal premium provided they extend the offer to include their employees under the plan. This provision we can support.

In conclusion, S. 2403 does not solve the problem of providing coverage to uninsureds. It would only place further burdens on the private system and will encourage greater abuses in the health care provider sector. Inevitably reduction in the protection afforded by private health plans will place new burdens on already over utilized government programs. We urge you to reject S. 2403 and to continue present broad tax incentives for American business to continue to provide effective employer sponsored health care plans without mandating the content and scope of these plans.

TESTIMONY

from

Robert Davis, Severna Park, Maryland

My wife and I have a beautiful six year old son who has a rare life-threatening seizure disorder. His illnesses are serious, last from two to four days and occur randomly. The resulting medical bills average about $1,200 to $1,600 per day. My son has had this medical disorder since three months of age.

I am a sales manager for a large computer company. I have over 15 years experience and am college educated. My family resides in Severna Park, Maryland. I have had to change jobs periodically in the past three years involving four employers. In all but one case, pre-existing medical exclusions in employer health insurance plans did not cover my son. These exclusions last(ed) up to one year.

My inability to get health insurance coverage for my son greatly increases financial pressure on my family and limits my employment alternatives. The paradox of this situation is that the government will not help me.

I have a home, two cars and savings. Therefore, since I have assets, current government programs cannot assist me. I can only be helped if my family becomes impoverished. This is ludicrous.

This legislation is needed to help middle-class Americans whom find themselves random victims of misfortune. I am willing to share the financial responsibility required by a state-risk-pooling program. I ask our legislative representatives to please expedite passage of this legislation, now.

Statement of the

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

to the

Senate Governmental Affairs Subcommittee on Intergovernmental Relations

on the

Access to Health Care Act of 1986

S 2403

June 26, 1986

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The American College of Emergency Physicians appreciates this opportunity to submit a written statement to the Senate Governmental Affairs Subcommittee on Intergovernmental Relations addressing the Access to Health Care Act of 1986, S 2403. The College believes the health care needs of the elderly, the disabled, and the less fortunate should be re-examined to assure access to high quality emergency medical care.

The College is a national medical specialty society founded in 1968 to improve emergency medical care in the United States. Our membership has grown to over 11,000 physicians who practice their specialty in emergency facilities across the nation. Last year, more than 78 million visits were made to emergency departments by patients who depended on emergency physicians to evaluate and treat their illnesses and injuries and to stabilize life- and limb-threatening conditions. Emergency medicine was recognized by the American Board of Medical Specialties in 1979 as the twenty-third medical specialty. Since the first board examination in emergency medicine was offered in 1980, more than 4,250 physicians have attained specialty certification in this new specialty. Today, there are 70 residency programs providing specialized training to more than 1,000 aspiring emergency physicians.

The practice characteristics of emergency physicians are unique. Twenty-four hours a day, seven days a week, emergency physicians provide care to patients seeking emergency treatment. They provide unscheduled, episodic, acute care to patients in need. Emergency physicians treat a wide range of medical conditions, from minor urgent problems to life- and limb-threatening emergencies. They must also recognize and treat child abuse and rape, burn victims, hypothermia victims, patients suffering potentially deadly allergic reactions, and patients presenting with a host of other conditions. Emergency physicians never know in advance how many patients they will be treating each day in the emergency department. They also have no advance knowledge of the severity of the illnesses or injuries they will be faced with as patients enter the emergency department. Emergency physicians provide definitive treatment, when appropriate, and are the link between pre-hospital systems and the emergency facility. The College and its membership are dedicated to the principle that all patients should have access to high quality emergency medical care.

Because of the unique aspects of emergency medicine practice, emergency physicians play a pivotal role in the delivery of medical care to the elderly, the disabled, the uninsured, and the underinsured. The emergency department often serves as the access point for patients entering the overall health care system. The elderly, the unemployed, and the indigent, particularly those who have no personal physician, frequently have nowhere to turn for their medical care except the emergency department. Emergency physicians have an ethical and legal obligation to evaluate, stabilize, and initiate treatment for all patients who present to the emergency department, regardless of their ability to pay.

The reality of this situation was reflected in recent studies conducted by Mathematica Policy Research, Inc., and by Medical Economics. According to these studies, emergency physicians provided as much as $400 million in uncompensated care in 1985. Emergency physicians everywhere are keenly aware of the uncompensated care problem in this country. As noted by the Medical Economics report, "a high proportion of emergency department patients either can't or won't pay, while medical ethics and the policy of most hospitals require that they be treated." Additionally, state and federal laws require that all patients entering the emergency department be given a medical screening examination. Because our overriding concern is with the welfare of patients, emergency physicians continue to provide a substantial amount of uncompensated care. Uncompensated care is not evenly distributed geographically or among physicians. Data indicate that 31% of emergency physicians' charges for services performed are uncompensated.

Changes in the health care marketplace, the growing number of under- and uninsured, and heightened competition among health care providers have driven increasing numbers of the poor, the unemployed, and the indigent to hospital emergency departments for both non-urgent and emergency medical care. Because emergency physicians frequently serve as the sole source of medical care for many of these patients, the past few years have witnessed a dramatic increase in the burden placed on these specialists to provide quality emergency medical care to all patients entering the emergency department. As greater numbers of the poor, uninsured, and indigent enter the overall health care system through the emergency department, less resources are available to the patient who is truly in need of emergency medical care. Therefore, national attention, including that of the American College of Emergency Physicians, has necessarily been focused on the issues of access and funding of uncompensated care for all providers, physicians and hospitals, alike.

The College applauds you, Senator Durenberger, in your efforts to address this crucial issue of access to health care. We note, however, that in S 2403, physician services are not covered by the financing mechanisms for uncompensated care. Any solution to this serious problem should include elements which assure that physicians and other health care providers will remain available to these patients. Because emergency physicians are major providers of medical care to the indigent and uninsured, the College offers its assistance to you as the Congress explores alternative solutions to access problems for those members of our society without adequate health care coverage. As always, the College is committed to quality emergency care for all patients.

Thank you for this opportunity to submit a written statement addressing the Access to Health Care Act of 1986.

THE CENTER FOR THE STUDY OF SOCIAL POLICY

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RECOMMENDATIONS FOR HEALTH INSURANCE RISK POLICY PROVISIONS OF THE ACCESS TO HEALTH CARE ACT OF 1986

(H.R. 4742 and S. 2402/S.2403)

The Access to Health Care Act of 1986 could significantly increase access to health insurance for persons with disabilities if:

1. States have the option to use Medicaid funding to subsidize premiums and deductibles on a sliding-scale basis to reduce the affordability problem which high risk pools create.

   This could be accomplished by amending existing Medicaid demonstration waiver authority under Chapter 1115 of the Social Security Act to permit state-wide demonstrations for potentially Medicaid eligible persons.

2. Benefits are broadened to cover on-going maintenance needs which many persons with disabilities have.

   High risk pools should cover all disability-related expenses certified as medically necessary by a physician including:

   a. durable medical equipment for purchase and repair;

   b. prosthetic devices;

   c. disposable medical supplies necessitated by bodily functions;

   d. prescription drugs and other medications;

   e. maintenance occupational or physical therapy for up to two hours per week.

   These items and services should be covered under home care as they would be covered if the insured was hospitalized.

3. Anti-discrimination laws are strengthened at the state and perhaps federal levels to discourage insurance companies from refusing or limiting coverage, or charging a higher rate for the same coverage because of a mental or physical disability without current valid actuarial evidence.

   To avoid dumping all persons with pre-existing conditions into high risk pools, appropriate standards of actuarial evidence need to be developed and consumers need to have the private right of action to sue for unfair discrimination and be able to collect attorney fees and court costs if successful.

--- Bob Griss

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COMMENTS ON THE HEALTH INSURANCE RISK POLICY PROVISIONS OF THE ACCESS TO HEALTH CARE ACT OF 1986
(H.R. 4742 and S.2402/S.2403)

High risk pools have had limited utility for younger working-age persons with permanent disabilities who need adequate and affordable health insurance in order to work.

1. The primary obstacle to high risk pools is the exorbitent cost to the consumer. This cost consists not only of the premium which is 150% of standard risk in most high risk pools, but also includes a deductible of $1,000 and a co-payment requirement of an additional $1,000 which people without on-going health care needs can usually avoid. A cost of $4,000 for an individual health insurance policy in a high risk pool would be about two-thirds of a minimum wage salary. Wisconsin's attempt to provide a modest subsidy for the premium of low income high risk persons has not increased participation of low income persons in its high risk pool. The importance of affordability is perhaps reflected in the fact that half of all people in high risk pools are in Minnesota which has the lowest premium levels.

2. Although described as "comprehensive," the benefit packages of the existing high risk pools are inadequate for many persons with disabilities providing insurance equivalent to catastrophic coverage for a non-disabled person. This neglects many on-going maintenance needs that a person with disabilities will have to pay for such as: durable medical equipment purchase and repair, prosthetic devices, disposable medical supplies, maintenance physical or occupational therapies (OT/PT), and personal care attendants, etc.

3. Insurance companies can exert pressure on the high risk pools to keep benefits limited and costs to the consumer high to reduce assessments on the insurance companies.

4. The use of general purpose revenue (GPR) funding to replace assessments on insurance companies because of the inequity of the ERISA exclusion for self-insured employers could create incentives for insurance companies to expand their definitions of the "uninsurable" population. Commercial health insurance companies have favored the high risk pool because they want to maintain the flexibility of rejecting people with pre-existing conditions. This could exacerbate the problems of enforcing state statutes to prevent unreasonable discrimination by insurance companies against persons with disabilities. In addition, depending on the financial burden which the high risk pool imposes on the individual with pre-existing conditions, this may effectively deny access to needed health care for many individuals who want to work. Instead of using GPR to replace assessments on insurance companies, GPR should be used to subsidize premiums and deductibles on a sliding-scale basis.

5. Existing high risk pools cover only a small fraction of high risk persons. No one knows the actual size of the so-called medically uninsurable population. While insurance actuaries may choose to reject a certain percentage of the population who apply for individual coverage, many people with comparable health status are in fact members of larger groups and thus receive health insurance through group policies. In a sense, medical uninsurability has more to do with the size of the group with which one shares risk than the nature of one's health care needs.

6. The AMA claims that an uninsured pool which includes persons with disabilities could provide premiums lower than individual policies for standard risk persons although slightly higher than a standard group rate as long as a

large percentage of low risk uninsured persons were included. This creates an opportunity for cross-subsidization which is advantageous to both low risk and high risk individuals.

7. If a public subsidy was available for both high risk and low risk individuals on a sliding fee scale for comprehensive insurance through an uninsured pool, there could be a significant reduction in the uninsured population in a cost-effective way. Insurers could compete for the uninsured pool offering different forms of managed care such as HMO coverage, and the costs for the insurance would come from (1) policy holders on a sliding fee scale, (2) employers who could not afford the high premiums in the absence of the sliding scale subsidy, and self-insured employers who were exempted from assessment by ERISA, and (3) a tax on insurance companies and other health care providers. In the absence of affordable health insurance coverage, the majority of working-age persons with severe disabilities have to stay out of the labor force in order to qualify for Medicaid or Medicare. In addition to the cost for health care services, this creates an additional need for publicly-financed income supports.

8. Federal legislation should permit states to establish an uninsured pool with assessment of insurance companies and self-insured employers for the health care needs of persons with pre-existing conditions who were rejected by insurance companies. (The assessment should be lower for disabled persons through the uninsured pool than through a high risk pool.) Instead of relying on a 10% excise tax on employers who do not contribute to the high risk pool, it would be useful to adopt the AMA proposal to provide a tax subsidy to employers for health care expenses as a business deduction contingent on contributing to an uninsured pool.

9. To avoid replicating the inadequacies of existing high risk pools, states should develop risk pools with lower costs for the consumer, more comprehensive benefit packages, and cost containment strategies which minimize the purchase of unnecessary and inappropriate health care services. It may be possible to reduce the size of the deficit for the high risk pool by lowering the cost to the consumer which in turn reduces adverse selection by increasing the participation of persons with lower risk. High risk pools may permit more efficient tailoring of adequate benefits for exceptional needs than would be possible in an uninsured pool where high risk persons would be a small minority.

10. Recognizing the limitations of standard insurance policies for persons with disabilities, states should consider the use of subsidized risk pools for wrap-around policies to supplement standard health insurance policies for on-going maintenance needs like durable medical equipment purchase and repair, prosthetic devices, disposable medical supplies, maintenance occupational or physical therapies, prescribed drugs, and personal care attendants, etc.

11. While proposing different solutions for persons with high risk and the uninsured and under-insured, the Access to Health Care Act of 1986 does not recognize the advantage of linking a high risk pool to an uninsured pool. Nor does the proposed legislation obligate employers who offer no health benefits to their employees to provide for health insurance and/or contribute to the high risk pool. It remains to be seen whether an inadequately developed high risk pool is a meaningful step in the direction of closing health care coverage gaps or diffuses support and diverts momentum from a more substantial step by appearing to make health care accessible to high risk persons.

Bob Griss

ACCESS TO HEALTH INSURANCE AND HEALTH CARE

BACKGROUND PAPER

PREPARED BY THE STAFF FOR USE OF
THE MEMBERS OF THE SUBCOMMITTEE ON
INTERGOVERNMENTAL RELATIONS

JUNE, 1986

ACCESS TO HEALTH INSURANCE AND HEALTH CARE

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Purpose

The purpose of this paper is to review federal involvement in financing access to health care services and to describe the gaps in coverage under these programs and plans. The discussion is divided into eight parts. Section 1 provides a brief history of federal programs and policies that provide access to health care for certain populations. Section 2 describes the uninsured population, followed by a discussion of the consequences of uninsurance for individuals and providers in sections 3 and 4, respectively. Sections 5 and 6 summarize hospital and state and local governments' respones to the uncompensated care problem. Section 7 discusses recently enacted legislation, 2 bills pending before congress, and whether there is a further federal role in addressing the uncompensated care dilemma. Finally, section 8 offers two broad strategies for solving the problem.

Brief History of Federal Involvement in Assuring Access to Health Care

Early Involvement

The federal government has a longstanding interest in assuring citizens' adequate access to quality health care. As early as 1798, with the establishment of the Marine Hospital Service to care for the nation's merchant seamen, Congress recognized the importance of health for not only the quality of life for the nation's citizens, but also for the strength of the national economy.

Through the years the federal interest in access to quality medical care has been asserted in different ways as the times and the health needs of the nation changed. President Lincoln established the Veterans' Administration health system to care for the injured veterans and the widows and orphans of soldiers killed in service to this country. The Public Health Service, formed in 1912, to treat ill sailors and merchant seamen returning to U.S. ports and to prevent the spread of infectious diseases through the civilian population, has continued to serve the nation's health needs. Today, the Public Health Service's role in the direct provision of medical care is limited, but it continues to meet the needs of special populations such as American Indians, and, through its National Institutes of Health, to provide world leadership in the development of new scientific knowledge and improved treatment for health problems.

Post World War II

While the federal government has been especially prominent in assuring access to quality medical care for special populations such as seamen, American Indians, and veterans, since World War II, Congress has enacted legislation guided by two broader policy objectives:

1. To increase the availability of high quality medical institutions and personnel; and

2. To reduce for all Americans the financial barriers to the use of medical institutions and personnel.

The federal government greatly increased the availability of hospital services through the Hill-Burton financing program initiated in 1946. This program provided federal funds to expand existing facilities and to build new hospitals in exchange for assurances that the hospitals would provide a certain amount of charity care to indigent patients.

The numbers of physicians and nurses were also greatly increased through a variety of federal programs beginning with the Health Professions Educational Assistance Act in 1963.

The federal government has acted to reduce financial barriers to medical care for Americans in three ways: Medicare, Medicaid, and the tax exclusion for employer-paid health benefits.

Medicare

The Medicare program, Title XVIII of the Social Security Act was enacted by Congress in 1965. The program covers hospital, physician, and other medical services for most citizens 65 years of age and over, disabled persons entitled to social security cash benefits for 24 months, and most persons with end stage renal disease. In FY 1987, Medicare will provide health insurance coverage for 31.8 million Americans at a cost of $80 billion.

Medicaid

Medicaid, Title XIX of the Social Security Act, was enacted by the Congress in 1965. Operating in every state, Medicaid is administered by the states and its cost is shared with the federal government. Although the states' shares vary, their average share of the total cost is about 45%. The program is designed to provide medical assistance to those groups or categories of people eligible to receive cash payments under one of the existing welfare programs established under the Social Security Act: Aid to Families with Dependent Children (AFDC), or the Supplemental Security Income (SSI) program for the aged, blind, and disabled. In 1987, Medicaid will cover about 28 million poor Americans, and the total cost to the federal government will be an estimated $27.4 billion.

Tax Exclusion

Since 1954, the Federal Tax Code has provided a double subsidy for health insurance bought for employees by employers. The employer's taxable income is reduced by the amount of the health insurance premiums paid, and the employee excludes the dollar value of the health insurance premium from his or her taxable income. This federal policy has been very successful in spreading the use of private health insurance throughout the population. A total of 146.4 million Americans, 61%, of all Americans are covered by employer-sponsored health insurance. Also, section 125 of the Internal Revenue Code permits employees to use employer-sponsored flexible spending accounts to pay for some uninsured, out-of-pocket medical expenses with before tax dollars. The FY1987 tax expenditure for employer sponsored health insurance is estimated to be $35.2 billion. The FY1987 tax expenditure for flexible spending plans is estimated to be $7.7 billion. By 1991 the combined tax expenditure for these benefits will be an estimated $72.4 billion (DHHS estimates).

Health System Reform

Health care financing in the United States is undergoing major reform. The federal government and the private sector are shifting from a cost-based reimbursement system to a prospective payment system. The Social Security Amendments of 1983 established the current payment system under which Medicare compensates hospitals for inpatient services. The goal of this reform was to introduce incentives for efficient delivery of health services, and, thereby, to slow the growth in Medicare's payments for hospital care. Payment rates are now set in advance for 468 diagnostic categories, known as diagnosis-related groups (DRGs). Hospitals must bear the loss if their costs exceed these payment amounts, and they may keep the profit should their costs be less than the payment amounts.

In the private sector, increased use of Health Maintenance Organizations, Preferred Provider Organizations, and the adoption of deductibles and coinsurance provisions in insurance policies are also contributing to a national decline in the length of hospital stay and in the cost of care for third party payers.

End of Cross Subsidation

An unfortunate, yet predictable, side effect of these new policies, however, is the demise of an important part of our nation's financing of care for low income and uninsured patients. Historically, health care for patients not covered by private insurance, Medicare, or Medicaid was provided by hospitals and doctors under the assumption that these costs could be recovered by overcharging those patients who were insured. As cost containment approaches in both the public and private sectors precipitate widespread use of prospective payment systems of reimbursement, the ability of hospitals and doctors to cost-shift is greatly reduced. With the elimination of this implicit source of funding for uninsured patients and the increasing level of competitiveness in the health services industry, hospitals and doctors are being forced to make the difficult choice of either experiencing financial distress due to unpaid services provided to uninsured patients or reducing the amount of care they provide to uninsured patients.

The Uninsured Population

Since the late 1970s, several national surveys have been completed which provide information on individuals' and families' health insurance status. Because these surveys ask questions regarding coverage in different ways, covering different time periods, and of different samples of the population, different estimates of the number of Americans uninsured for medical expenses have been reported. The following represents the best information currently available.

The 1977 National Medical Care Expenditure Survey (NMCES) estimated that 9.5 percent of the population under age 65 was always uninsured, and that an additional 8.3% was uninsured part of the year(1).

A study by the Robert Wood Johnson Foundation reported in 1983 that 12% of all Americans are without health insurance(2).

A 1984 study by the Urban Institute reported that 16% of the U.S. population lacked health insurance(3).

The most comparable data on insurance status over the past six years come from the annual Current Population Survey (CPS) conducted by the U.S. Bureau of the Census. In these annual surveys the sampling techniques are the same, the wording of questions is identical, and the survey is administered during the same month (March) each year. From this survey may be calculated the number of citizens who are uninsured during any given month of the year. Data from the CPS for selected years are presented in table 1.

The studies cited above indicate that the uninsured are a diverse group spanning a wide range of ages and incomes.

Table 1: Estimates of Uninsured People From the Current Population Survey 1980-1985(Source: Congressional Budget Office).

Survey Year	Number of Uninsured People	Percent of U.S. Noninstitutionalized, Civilian Population
1980	29.5 million	13.5%
1882	31.2 million	14.0%
1984	35.3 million	15.0%
1985	37.1 million	15.9%

According to the 1982 Urban Institute Study (4) by Katherine Swartz (using CPS data):

35% of all uninsured people were below the poverty line;

25% of the uninsured were full-time workers for 40 weeks or more;

36% of the uninsured population were children;

Of the uninsured children, 36% lived with parents who had insurance, implying that families have trouble insuring everyone, and that companies may be curtailing coverage for dependents.

A striking finding comes from the 1977 National Medical Care Expenditure Survey (5):

77.9% of the uninsured population consists of employed people and their dependents.

If these workers were offered and accepted family health coverage, three quarters of those uninsured for health expenses would be covered.

Additional data on the insurance status of employed persons are provided in table 2.

Consequences of Lack of Insurance for Individuals and Families

Data from several national studies indicate that the uninsured as a group have more health problems yet receive less medical care than the uninsured.

Insurance coverage can affect the use of health services in a number of direct and indirect ways. Some hospitals refuse admission to patients without insurance unless substantial preadmission deposits are paid. Physicians also may decline to take patients who cannot pay at the time care is provided. Furthermore, many patients are reluctant to seek care because other pressing needs, food for their families, transportation to work, heating bills, and rent for instance, take precedence. Under these circumstance, seeing a physician may be postponed until serious illness or a life-threatening event occurs.

Table 3 shows data from the 1977 National Medical Care Expenditure Survey on physician visits per year for people under age 65. Over all, these data show that uninsured people average 2.4 physician visits per year while insured people average 3.7 visits per year, 54% more visits than for the uninsured. Moreover, insured persons have higher physician visit rates regardless of race, age, or location of residence.

Differences in the use of health care between the insured and uninsured also extend to hospital care. Individuals covered by insurance receive over 90% more hospital care than the uninsured do. Table 4 shows the extent of difference in hospital use. The largest differences are found among those aged 19-24, living in the Southern United States, and living in rural areas.

Some of these differences in hospitalization may be attributed to self-selection: those who expect to be hospitalized may be more likely to arrange for coverage. Also, some uninsured individuals may become eligible for Medicaid assistance when they incur large medical bills. Some of the difference may be the result of overuse of hospital services by the insured, especially since these data come from a pre-prospective payment system year. But these explanations cannot account entirely for such significant differences in the use of hospital care between people with and without insurance.

Lower rates of physician visits and hospitalization by the uninsured are not a reflection of lower need for health care. In fact, the uninsured appear to be in somewhat poorer health than the insured. NCHSR data show that the uninsured spend one-third more days in bed per year than the insured do, and they are 33% more likely to rate their health as fair or poor. When physician visits for people with comparable health status are compared, insured people still have higher physician visit rates (see table 5).

Figure 1 from the 1983 Robert Wood Johnson Foundation Updated Report on Access to Health Care for the American People (6) presents data on a number of different measures of health status and access to health services. These data reveal that the uninsured:

Believe themselves to be in fair or poor health to a greater extent than insured persons.

Are more likely not to have seen a physician in the past 12 months.

Are more likely not to have a regular source of care, were more likely to report that they needed health care in the past year but did not obtain it.

Are more likely to report that serious illness caused financial problems.

Are more likely to report that they were refused care for financial reasons.

Consequences for Providers

While the rates of use of physician and hospital services for uninsured persons are consistently below those for insured persons, physicians and hospitals do, in fact, provide large amounts of uncompensated care, much of it to uninsured people.

Uncompensated care is usually defined as including charity care provided by a hospital to those who cannot pay for it, as well as bad debts arising from care of patients who presumably can pay but who do not. In reality it is impossible to separate true charity care provided to poor uninsured patients from true bad debt care arising from patients' refusal to pay and/or inadequate hospital collection procedures.

Data from the American Hospital Association reveal that community hospitals provided 6.2 billion worth of uncompensated care in 1982. This represented 5% of hospital charges. Of this total, $1.7 billion was clearly identifiable as charity care (7).

The uncompensated care burden has increased in recent years. The dollar amount of such care increased from $4.2 billion in 1978 to $6.2 billion in 1982 (in 1982 dollars).

While the total amount of uncompensated care is not large - 6% of total community hospital patient revenue and 5% of charges - it is not evenly distributed among hospitals.

As is shown in figure 2, teaching and government (city and county) hospitals provide a high level of uncompensated care relative to their charges. Teaching hospitals, for example, accounted in 1982 for 27% of charges but 35% of all uncompensated care. The greatest burden falls on government teaching hospitals. Their charges represent just 6.4% of all community hospital charges, yet they provide 17.7% of all uncompensated care.

Nonteaching voluntary (nonprofit) and investor-owned hospitals bear a disproportionately small burden of uncompensated care in relation to their share of hospital charges.

Recent research by Sloan, Valvona, and Mullner (7) indicates that uncompensated care has a harmful effect on the financial status of hospitals. Both liquidity and profitability decline as uncompensated care increases. Additional research by Feder and Hadley support this conclusion. They found that while most hospitals were financially healthy in 1980, almost a quarter had bottom-line deficits. About one-quarter of the hospitals in deficit - approximately 300 hospitals - provided exceptionally high volumes of care to the poor (Medicaid, charity, and bad debt) and together accounted for almost one-fifth of the nation's total care to the poor. These researchers conclude that " these hospitals, heavily concentrated in the nation's largest cities, faced financial pressure that could jeopardize their ability to maintain needed service."

Hospital Responses to the Uncompensated Care Problem

Data on hospital actions to reduce or avoid uncompensated care are, unfortunately, fragmentary. There is much anecdotal evidence of patient transfers and outright refusals of care because patients are uninsured. One systematic study (8) of patient transfers to the emergency room at Cook County Hospital in Chicago during 1983-84 revealed:

81% were unemployed;

87% were transferred because they lacked adequate medical insurance;

Only 6% of the patients had given informed consent for the transfer;

24% of the patients were in an unstable clinical condition at the transfering hospital;

22% required admission to an intensive care unit, usually within 24 hours of arrival.

The proportion of transferred patients who died, 9.4%, was 2 1/2 times as great as the proportion of medical-service patients who were not transferred, 3.8%

The Congress recently addressed this particular problem with legislation in the Consolidated Omnibus Budget Reconciliation Act of 1986 requiring hospitals participating in the Medicare program to provide emergency services for people with an urgent need for care, including women in labor, regardless of their ability to pay. This provision, of course, does not solve the problem of how to pay for the care hospitals and doctors are now required by law to provide to poor, uninsured patients.

While hospitals are now required to provide care to emergency patients under certain conditions, it is clear that the general trend is for hospitals to place limits on the amount of free care they provide. Sloan, Valvona, and Mullner (7) report data from the American Hospital Association indicating that hospitals are placing explicit limits on the amount of uncompensated care they will provide. About 15% of hospitals adopted explicit limits on the amount of charity care they provided in 1981 and 1982. Hospitals that have traditionally provided large amounts of such care (such as teaching hospitals) make up a large proportion of those adopting limits. In particular, 26% of public hospitals which are members of the Council of Teaching Hospitals adopted such ceilings.

Responses of State and Local Governments

As of July 1985, there were 34 states with state indigent care programs of some type (9). In four states, Arkansas, Oklahoma, South Carolina, and Texas, the statewide indigent care program was not operational as of October 1985. In the 16 states that do not have a state indigent care program, counties and municipalities usually have some legal responsibility for providing medical care to their residents. However, these requirements are often broad and imprecise, leading to a variety of interpretations about benefit coverage, eligibility standards and program administration.

States are increasingly under pressure to initiate new or expanded indigent care programs. According to the Intergovernmental Health Policy Project, 22 states introduced legislation in 1984 to increase health care access for the medically indigent. In 1985, 30 states considered legislative proposals that either would have mandated improvements in state or county indigent care programs or would have required establishing a commission to examine the issue.

Of the 30 states that considered indigent care legislation in 1985, eight states altered their existing indigent programs, and four - Arkansas, Nevada, South Carolina, and Texas - adopted legislation creating new state indigent care programs.

Current Federal Initiatives

As the question of what is the federal role in assuring access to health care continues to be debated, various legislative proposals in the 99th Congress have been introduced and some enacted into law that provide some degree of coverage for certain individuals.

Summary of Continued Health Insurance Coverage (Section 10001 PL 99-272)

The recently enacted consolidated Omnibus Budget Reconciliation Act of 1985 (Section 10001, PL 99-272) contains a provision that amends ERISA, the Code, and the Public Health Service act and requires employees to provide continued health insurance coverage for certain employees and family members. Section 10001 of COBRA is included at the end of the reference section of this paper.

a. Covered Employers

The changes in ERISA and the code do not apply to churches, Federal, State and local governments and employers of fewer than 20 employees.

b. Required Coverage

Qualified beneficiaries include widows, divorced spouses and persons whose spouses become eligible for Medicare, as well as dependents of such beneficiaries. Coverage for these individuals will be provided for three (3) years. Qualified beneficiaries also include terminated employees, and their coverage must be provided for 18 months.

The cost of coverage must not exceed 102% of the premium and this entire amount may be charged to the qualified beneficiary.

Recent Legislative Proposals

Those bills recently introduced in the 99th Congress woiuld amend either the Public Health Service Act (S.2402) or the Internal Revenue code (S.2403) and (H. R. 4742) to assure access to health insurance for certain individuals:

* S.2402 (Kennedy, May 2, 1986)

* S.2403 (Durenberger, May 2, 1986) Access to Health Care Act of 1986

* H.R. 4742 (Stark, May 1, 1986) Health Care Imposed Access Act of 1986

A summary of S. 2403 (Durenberger) is included in the Appendix as Table 6. The essential difference between S. 2403 and S. 2402 is in the penalties assessed against employers or states that fail to meet certain requirements.

I. If a state fails to develop a state plan for the uninsured and underinsured:

S. 2403 - A state would risk losing matching federal funds for Medicaid administrative expenses.

S. 2402 - A state would risk losing its Public Health Service Act funds.

II. If an employer fails to contribute to the statewide insurance pools:

S. 2403 - The employer would be subject to an excise tax equal to 10% of the expenses for employee health benefits.

S. 2402 - The employer would be subject to a civil penalty.

- Section 4 of both S. 2402 and 2403 amend the continuity provision of COBRA. Under current law, an employer is required to extend coverage for 18 months for a terminated employee. Section 4 of S. 2402 and S. 2403 would extend that coverage by 4 months to 22 months.

A fourth legislative proposal has been introduced:

* S. 1620 (Durenberger, September 10, 1985) - The National Council on Access to Health Care. This bill would establish an advisory council, made up significantly of health care consumers and providers as a national forum and focus for addressing access to health care.

Some problems have surfaced from the employer perspective regarding the Continued Health Coverage provision of COBRA:

1) No regulations have been written yet, and it is unlikely they will be in the near future. The effective date of the law, however, is July 1, 1986.

2) The employers have the burden of notifying the covered beneficiaries of this coverage option, which could prove to be very expensive to do.

Is There a Federal Role?

Some Federal officials and members of Congress argue that the problem of uncompensated care is not a direct concern of the federal government. Those favoring this position argue that Medicare takes care of its beneficiaries, including the bad debts of its beneficiaries, and its responsibility is the proper stewardship of the Medicare Trust Fund. Furthermore, Medicaid provides access to medical care for the poorest of the federally designated poverty population, and the federal government contributes approximately 60% of all Medicaid expenditures. In addition, through many grant programs, the federal government meets health services requirements for certain categories of individuals such as veterans and American Indians. In effect, the argument is that the federal government is doing its share already. Now, the federal deficit, Medicare's long term financial problems, and the presence of many other unmet health and social needs make federal officials and some members of Congress unenthusiastic about accepting responsibility for indigent health care programs that almost certainly entail new costs.

Proponents of federal action argue that federal policy must address directly the questions of uninsurance and uncompensated care. The absence of an explicit policy puts pressure on other parts of the legal and economic system to respond to the problems. Hence, programs such as voluntary health insurance for layed-off workers and their dependents, and federal requirements that hospitals provide emergency care without regard to patient's ability to pay are being generated that are too limited in scope and that do not provide adequate funding to solve the problems. Also, the potential for a truly competitive health system, which the Administration and the Congress have argued for over six years to be in the national interest, is seriously undermined by the presence of large numbers of uninsured people who will be left out of a competitive health care market. Proponents of federal action argue that problems of poverty can best be addressed by the federal government with its large revenue-raising opportunities and its capacity for balancing the uneven distribution of wealth and other resources in the country.

Finally, President Reagan in his State of the Union message in January, 1986, called for a major effort on welfare reform. It is expected that any national policy consensus on this subject must address the role of the Federal Government in providing access to health care for those not covered by private or social insurance systems

Two Broad Strategies for Solving the Problem

Two broad strategies are available to government for improving access for the uninsured to the health care system(10). The first and simplest is to enable more people to obtain some form of health insurance. The second is to pay hospitals and other providers directly to care for the poor and other uninsured patients. While strong arguments can be made to support both positions, it is probably the case that both strategies will have to be pursued.

Expanded insurance coverage would remove barriers to prompt care and encourage people to obtain necessary care early in the course of an illness, rather than delaying help-seeking out of fear of being refused care by hospitals and doctors or of being burdened with debt they have no hope of repaying. Insurance also removes the stigma of welfare relief many people associate with the provision of charity care. Finally, the overall cost to society of caring for patients will be lower if they are enrolled in managed health benefit plans rather than left outside the system until severe illness strikes.

In the absence of some federally mandated universal health plan coverage such as is commonly found in Canada and Europe, however, there will probably always be some number of individuals uncovered for medical expenses. Some means of reimbursing hospitals and physicians directly for providing care to these people may be required.

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1882	31.2 million	14.0%
1984	35.3 million	15.0%
1985	37.1 million	15.9%

Table 2. Employment and health insurance coverage: Percent of employed persons by health insurance status according to selected characteristics. NMCES Health Insurance Employer and Household Surveys, United States, 1977.

Characteristics	Total employed (thousands)	Private insurance all year	Private insurance part year	Public insurance all or part year	Uninsured all year
		Percent of employed persons			
Employed all or part year[a]	106,184	83.7	3.3	4.3	8.7
Age in years					
16-18	8,395	81.0	1.9	8.1	9.0
19-24	19,534	74.4	6.9	5.7	13.0
25-30	17,711	82.0	4.4	5.2	8.5
31-40	22,018	85.5	2.6	4.3	7.6
41-54	25,176	89.0	1.6	2.3	7.1
55-64	13,350	88.8	1.9	2.4	7.0
Sex					
Male	57,922	84.3	3.2	3.0	9.4
Female	48,262	83.0	3.4	5.8	7.7
Color					
White	93,813	85.2	3.3	3.3	8.1
Nonwhite	12,371	72.4	3.1	11.6	12.9
Education in years					
Less than 12	29,830	75.9	3.3	8.2	12.6
12	38,160	86.4	3.3	2.8	7.4
13-15	16,110	86.3	3.5	2.2	8.0
16 or more	15,112	92.6	3.2	1.1	3.1
Marital status					
Never Married	25,964	77.3	4.7	6.0	12.0
Married	66,348	88.6	2.6	2.2	6.5
Widowed	23,211	79.7	4.0	4.0	12.3
Separated	2,774	64.2	4.7	17.1	14.1
Divorced	5,782	69.1	4.8	12.1	14.0
Perceived health status					
Excellent	50,787	86.6	3.6	2.8	7.0
Good	41,723	83.2	2.8	4.7	9.3
Fair	9,491	77.3	3.9	8.3	10.5
Poor	1,637	66.1	1.8	14.7	17.4
Region					
Northeast	21,985	89.8	1.5	3.4	5.5
North Central	31,666	87.2	3.6	3.9	5.4
South	32,808	80.5	3.5	4.3	11.7
West	19,724	76.9	4.6	5.9	12.6
Employment status					
Wage Earner	91,319	84.3	3.4	4.3	8.0
Full-time	72,125	85.9	3.6	3.5	7.0
Part-time	19,194	78.1	2.8	7.3	11.8
Self-employed	7,570	80.5	2.4	2.0	15.0
Full-time	5,827	81.3	2.4	1.4	15.0
Part-time	1,743	77.3	2.4	5.0	15.4
Farm worker/unknown	2,103	80.1	2.3	3.1	14.4

Table 2. (continued)

Characteristics	Total employed (thousands)	Private insurance all year	Private insurance part year	Public insurance all or part year	Uninsured all year
			Percent of employed persons		
Industry					
Agriculture, forestry, fishing	2,662	71.2	3.6	3.5	21.7
Construction	4,980	72.7	4.2	4.9	18.2
Manufacturing	16,100	88.6	3.0	3.7	4.8
Transportation, communication, utilities	6,166	92.4	1.9	1.3	4.4
Sales	18,898	80.7	3.4	5.1	10.8
Finance and insurance	5,185	87.8	3.9	3.3	5.0
Repair services	4,922	78.7	3.8	4.3	13.2
Personal services	3,262	67.8	4.2	12.0	16.0
Entertainment and recreation	1,374	71.2	5.1	5.6	18.1
Professional services	12,338	87.6	3.0	3.2	6.3
Public Administration	2,628	87.7	1.5	1.1	9.7
Occupation					
Professional and technical	15,673	91.0	2.7	1.8	4.6
Managerial and administrative	8,031	89.9	4.6	1.0	4.5
Sales	6,176	86.4	3.7	2.2	7.7
Clerical	14,869	88.1	2.6	3.5	5.8
Craftsmen and foremen	10,366	83.9	3.3	3.3	9.5
Operatives	10,842	84.2	4.0	5.8	6.1
Transportation operative	3,816	84.0	2.1	3.0	10.9
Service workers	15,859	74.7	4.0	8.8	12.5
Laborers (non-farm)	4,812	73.1	3.4	5.6	17.9
Farmers (owners, managers)	1,379	85.2	1.5	1.2	12.1
Farm laborers and foremen	958	69.4	2.7	7.1	20.8
Family Income					
Poor/near-poor	9,244	50.8	4.4	21.6	23.3
Low income	12,317	67.8	6.0	8.7	17.5
Middle income	41,282	85.8	3.8	2.4	8.0
High income	43,400	93.3	1.9	1.1	3.7
Hourly wage rate					
\$2.50 or less	10,816	67.9	3.7	11.0	17.4
\$2.51 to \$5.00	42,890	79.3	4.0	5.2	11.4
\$5.01 to \$7.50	19,346	91.8	2.9	1.1	4.2
\$7.51 to \$10.00	9,058	93.8	1.4	1.7	3.1
\$10.01 and above	5,640	92.6	2.2	1.9	3.3
Income/Earnings			Mean Value[b]		
Household income (all sources)		\$23,994 (\$376)	\$18,271 (\$1,267)	\$11,390 (\$844)	\$14,883 (\$753)
Hourly wage rate		\$5.56 (\$.07)	\$4.40 (\$.15)	\$3.63 (\$.20)	\$3.87 (\$.15)
Marginal tax rate of tax filing unit (includes Federal, state and social security taxes)		29.8% (.24%)	25.6% (.74%)	13.0% (.69%)	20.6% (.63%)

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[a] Includes all other ethnic/racial groups not shown separately, persons with unknown education, marital status, health status, hours of work, earnings, wages, industry or occupation.
[b] Standard errors in parentheses.

Source: National Center for Health Services Research and Health Care Technology Assessment.

DIC/AMNESYA3b:04/29/85

Table 3:

Physician Visits Per Year for People Under Age 65, by Insurance Status, Race, Age, Region, and Residence, 1977

Source: unpublished data from National Medical Care Expenditure Survey, National Center for Health Services Research, 1977.

	Uninsured	Insured	Ratio, Insured to Uninsured
Total	2.4	3.7	1.54
Race			
White	2.5	3.7	1.48
Black and Other*	1.6	3.2	2.00
Age			
Under 6	3.0	4.0	1.33
6-18	1.6	2.6	1.63
19-24	2.2	3.6	1.64
25-54	2.6	3.9	1.50
55-64	3.1	5.1	1.65
Region			
South	2.1	3.5	1.67
Non-South	2.6	3.8	1.46
Residence			
SMSA**	2.4	3.8	1.58
Non-SMSA**	2.3	3.3	1.43

* Includes Hispanics, Native Americans and other minorities.

** Standard Metroplitan Statistical Area

Table 4:

Hospital Days Per 100 Persons Under Age 65, by Insurance Status, Race, Age, Region, and Residence, 1977

Source: unpublished data from National Medical Care Expenditure Survey, National Center for Health Services Research, 1977.

	Uninsured	Insured	Ratio, Insured to Uninsured
Total	47	90	1.91
Race			
White	44	86	1.95
Black and Other*	60	116	1.93
Age			
Under 6	33	50	1.51
6-18	15	27	1.80
19-24	23	86	3.74
25-54	69	110	1.59
55-64	104	201	1.93
Region			
South	35	104	2.97
Non-South	56	84	1.50
Residence			
SMSA**	50	86	1.72
Non-SMSA**	42	99	2.36

* Includes Hispanics, Native Americans, and other minorities.

** Standard Metropolitan Statistical Area.

Table 5:

Physician Visits Per Year for People Under Age 65 in Fair or Poor Health, by Insurance Status, Race, Age, Region, and Residence, 1977

Source: unpublished data from National Medical Care Expenditure Survey, National Center for Health Services Research, 1977.

	Uninsured	Insured	Ratio, Insured to Uninsured
Total	4.1	6.9	1.68
Race			
White	4.5	7.2	1.60
Black and Other*	2.6	5.7	2.19
Age			
Under 6	4.7	5.6	1.19
6-18	4.7	4.8	1.02
19-24	3.4	7.5	2.21
25-54	4.3	7.2	1.67
55-64	3.8	7.6	2.00
Region			
South	3.8	6.1	1.61
Non-South	4.5	7.4	1.64
Residence			
SMSA**	4.1	7.2	1.76
Non-SMSA**	4.2	6.3	1.50

* Includes Hispanics, Native Americans and other minorities.

** Standard Metropolitan Statistical Area.

Table 6

Summary of S. 2403, the Access to Health Care Act of 1986.

Sec. 1 Short Title: "Access to Health Care Act of 1986"

Sec. 2 Incentives for the establishment of statewide insurance pools.

Sec. 2 places an excise tax on large employers equal to 10 % of the expenses for the employee health benefits if that employer does not participate in a state established health insurance pooling association. The section defines the minimum standards for a qualified health insurance pooling association. Such association must offer individuals and their dependents who are residents of the state, and not medicare eligibles, a health insurance policy which at minimum has: A limit of annual out-of-pocket expenses for covered services of $1500.00 for individual coverage and $3000.00 for family coverage.

A lifetime limit of payment for covered services for any individual not less than $500,000.

Deductibles which do not exceed $1000.00, and denies covered services for preexisting conditions for no more that 6 months.

The pool premium rate is not to exceed 150% of the average premium rates for individual standard risks in the state for comparable coverage.

The losses to the pool will be assessed equally by the association and all its participating members.

Sec. 3 Requiring state programs for the uninsured and under insured.

Sec. 3 requires the States to develop programs to meet health care needs for its uninsured and underinsured residents. The states are at risk of losing federal matching funds for Medicaid administrative expenses if they fail to develop the program by January 1, 1988 or on the first January 1 following state legislative sessions which do not occur before January 1, 1988.

In developing programs, states may either provide for health coverage - by the means it determines. The coverage may6 be in the form of a health maintenance organization or other managed system of care or traditional insurance. Or, the States may develop a program which remunerates hospitals for the inpatient and outpatient uncompensated and charity care these institutions provide to the uninsured and underinsured.

Sec. 4 Temporary extension of coverage for laid-off workers; open enrollment for spouses of unemployed workers.

Sec. 4 ammends the section of the Consolidated Omnibus Budget Reconciliation Act of 1985 which requires employers to offer terminated employees and their dependents the option to maintain their participation in the employer's health insurance group coverage (if the beneficiary pays the premium costs).

A. the Ammendment would require employers to maintain its contribution to the health benefits for a period up to 4 months if the employee has been laid-off involuntarily.

the ammendment also requires that employers provide employees an open-enrollment period to sign for health insurance when that employee's spouse has lost employment and the family was covered only on the former employer's health benefit program.

Sec. 5 Deduction allowable for certain group health plan contributions by self-employed individuals.

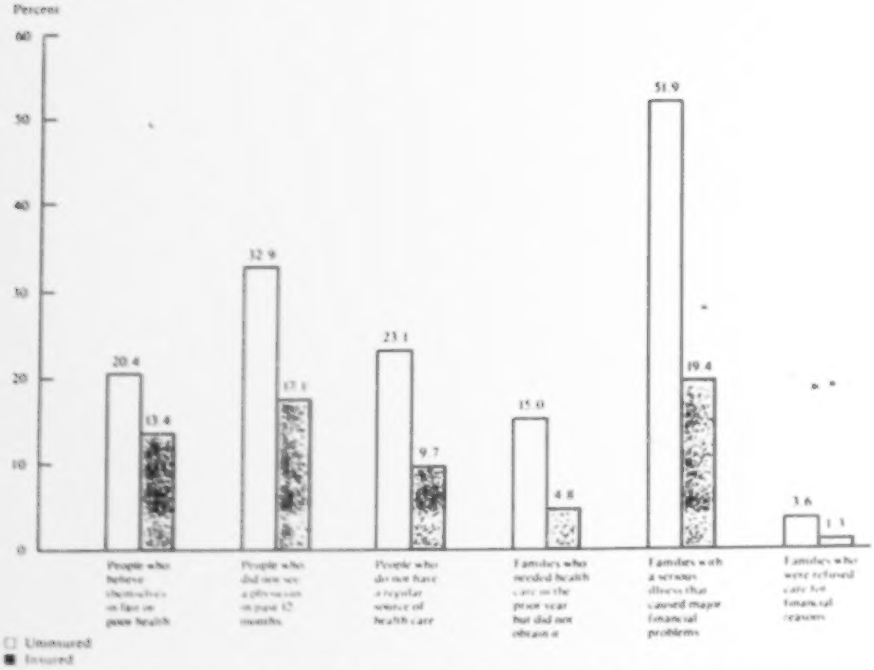
Sec. 5 allows self-employed individuals to take a business deduction for health benefits when that individual provides health insurance coverage to his or her employees. For the payers of the provivision the tax deduction cannot exceed the lowest paid employee contribution made to the firm's health plan.

Sec. 6 Demonstration Projects on improving access to health insurance for small employers and self employed individuals.

Sec. 6 instructs the Secretary of Health and Human Services to carry out studies and demonstration projects on ways to reduce the costs of obtaining health insurance for small employers and self-employed individuals. The Secretary is to report back to Congress by January 1, 1988 on these projects.

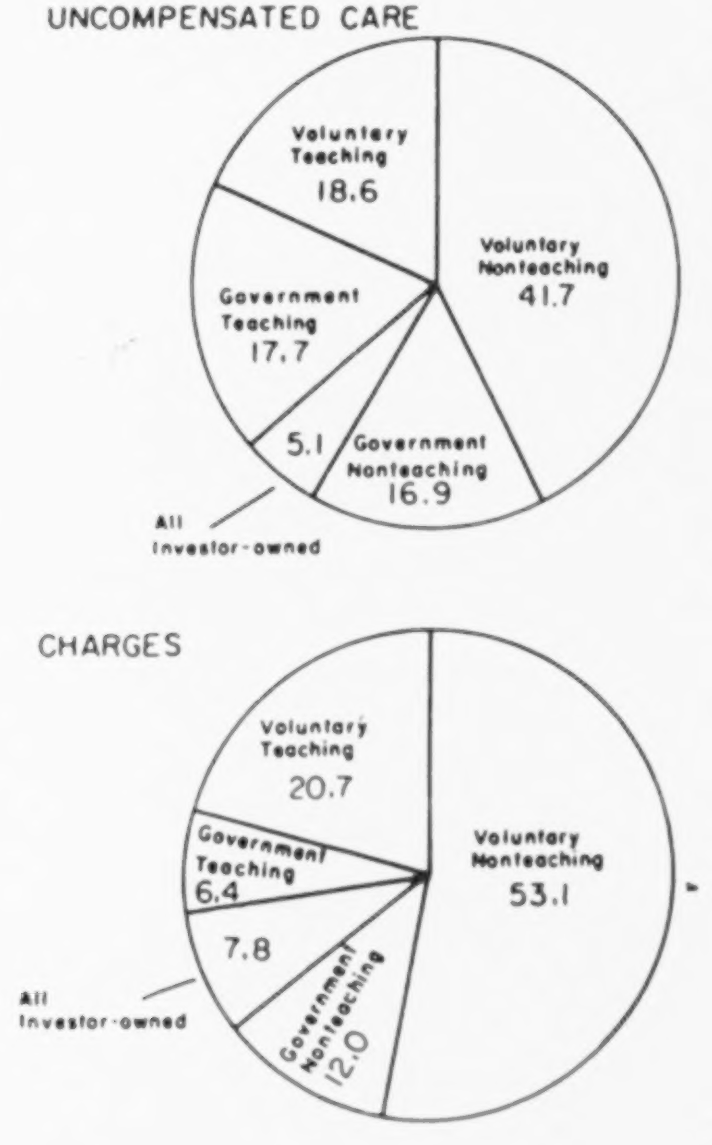
Figure 8:

The uninsured vs. the insured, 1982



Source: *Updated Report on Access to Health Care for the American People, Special Report*, No. One, Princeton, New Jersey: The Robert Wood Johnson Foundation, 1983, p. 6.

Fig. 2 Volume of uncompensated care versus charges by hospital type, 1982 (percentage distribution)



(1) the recommendations developed under subsection (c), including an explanation of the reasons for their selection, and

(2) such recommendations for additional activities respecting long-term health care policies as the Task Force finds appropriate.

The Secretary, in cooperation with the National Association of Insurance Commissioners, shall provide for the dissemination of the report to each of the States.

(e) Termination of Task Force.—The Task Force shall terminate 90 days after the date of submission of the report required under subsection (d).

(f) Reports of Secretary.—The Secretary shall transmit to the Committee on Energy and Commerce of the House of Representatives and to the Committee on Labor and Human Resources of the Senate two reports on—

(1) actions taken by the States to implement the recommendations developed under this section and to recommend additional action; and

(2) recommendations for legislative and administrative action, if any, needed to respond to issues raised by the Task Force or to improve consumer protection with respect to long-term health care policies.

The first report shall be transmitted 18 months after the date the report is made under subsection (d), and the second report shall be transmitted 18 months later.

(g) Long-Term Health Care Policy Defined.—In this section, the term "long-term health care policy" means an insurance policy, or similar health benefits plan, which is designed for or marketed as providing (or making payments for) health care services (such as nursing home care and home health care) or related services (which may include home and community-based services), or both, over an extended period of time.

(h) Assurance of States' Jurisdiction.—Nothing in this section shall be construed as recommending Federal preemption of the States in overseeing the operation and regulation of insurance carriers in their respective jurisdictions.

TITLE X—PRIVATE HEALTH INSURANCE COVERAGE

SEC. 10001. EMPLOYERS REQUIRED TO PROVIDE CERTAIN EMPLOYEES AND FAMILY MEMBERS WITH CONTINUED HEALTH INSURANCE COVERAGE AT GROUP RATES (INTERNAL REVENUE CODE AMENDMENTS).

26 USC 162.

(a) Denial of Deduction for Employer Contribution to Plan.—Subsection (i) of section 162 of the Internal Revenue Code of 1954 (relating to deduction for trade or business expenses with respect to group health plans) is amended by redesignating paragraph (2) as paragraph (3) and by inserting after paragraph (1) the following new paragraph:

"(2) Plans must provide continuation coverage to certain individuals.—

"(A) In general.—No deduction shall be allowed under this section for expenses paid or incurred by an employer for any group health plan maintained by such employer unless all such plans maintained by such employer meet the continuing coverage requirements of subsection (k).

"(B) EXCEPTION FOR CERTAIN SMALL EMPLOYERS, ETC.—Subparagraph (A) shall not apply to any plan described in section 106(b)(2).".

(b) DENIAL OF EXCLUSION FOR HIGHLY COMPENSATED INDIVIDUALS.—Section 106 of the Internal Revenue Code of 1954 (relating to contributions by employer to accident and health plans) is amended by inserting "(a) IN GENERAL.—" before "Gross" and by inserting at the end thereof the following new subsection: 26 USC 106.

"(b) EXCEPTION FOR HIGHLY COMPENSATED INDIVIDUALS WHERE PLAN FAILS TO PROVIDE CERTAIN CONTINUATION COVERAGE.—

"(1) IN GENERAL.—Subsection (a) shall not apply to any amount contributed by an employer on behalf of a highly compensated individual (within the meaning of section 105(h)(5)) to a group health plan maintained by such employer unless all such plans maintained by such employer meet the continuing coverage requirements of section 162(k).

"(2) EXCEPTION FOR CERTAIN PLANS.—Paragraph (1) shall not apply to any—

"(A) group health plan for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year,

"(B) governmental plan (within the meaning of section 414(d)), or

"(C) church plan (within the meaning of section 414(e)).

Under regulations, rules similar to the rules of subsections (a) and (b) of section 52 (relating to employers under common control) shall apply for purposes of subparagraph (A).

"(3) GROUP HEALTH PLAN.—For purposes of this subsection, the term 'group health plan' has the meaning given such term by section 162(i)(3).".

(c) CONTINUATION COVERAGE REQUIREMENTS.—Section 162 of the Internal Revenue Code of 1954 is amended by redesignating subsection (k) as subsection (l) and by inserting after subsection (j) the following new subsection: 26 USC 162.

"(k) CONTINUATION COVERAGE REQUIREMENTS OF GROUP HEALTH PLANS.—

"(1) IN GENERAL.—For purposes of subsection (i)(2) and section 106(b)(1), a group health plan meets the requirements of this subsection only if each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled to elect, within the election period, continuation coverage under the plan.

"(2) CONTINUATION COVERAGE.—For purposes of paragraph (1), the term 'continuation coverage' means coverage under the plan which meets the following requirements:

"(A) TYPE OF BENEFIT COVERAGE.—The coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred.

"(B) PERIOD OF COVERAGE.—The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

"(i) Maximum period.—In the case of—

"(I) a qualifying event described in paragraph (3)(B) (relating to terminations and reduced hours), the date which is 18 months after the date of the qualifying event, and

"(II) any qualifying event not described in subclause (I), the date which is 36 months after the date of the qualifying event.

"(ii) End of plan.—The date on which the employer ceases to provide any group health plan to any employee.

"(iii) Failure to pay premium.—The date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary.

"(iv) Reemployment or medicare eligibility.—The date on which the qualified beneficiary first becomes, after the date of the election—

"(I) a covered employee under any other group health plan, or

"(II) entitled to benefits under title XVIII of the Social Security Act. 42 USC 1395c.

"(v) Remarriage of spouse.—In the case of an individual who is a qualified beneficiary by reason of being the spouse of a covered employee, the date on which the beneficiary remarries and becomes covered under a group health plan.

"(C) Premium requirements.—The plan may require payment of a premium for any period of continuation coverage, except that such premium—

"(i) shall not exceed 102 percent of the applicable premium for such period, and

"(ii) may, at the election of the payor, be made in monthly installments.

If an election is made after the qualifying event, the plan shall permit payment for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

"(D) No requirement of insurability.—The coverage may not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

"(E) Conversion option.—In the case of a qualified beneficiary whose period of continuation coverage expires under subparagraph (B)(i), the plan must, during the 180-day period ending on such expiration date, provide to the qualified beneficiary the option of enrollment under a conversion health plan otherwise generally available under the plan.

"(3) Qualifying event.—For purposes of this subsection, the term 'qualifying event' means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this subsection, would result in the loss of coverage of a qualified beneficiary:

"(A) The death of the covered employee.

"(B) The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.

day before the qualifying event for that employee, is a beneficiary under the plan—

"(I) as the spouse of the covered employee, or

"(II) as the dependent child of the employee.

"(ii) Special rule for terminations and reduced employment.—In the case of a qualifying event described in paragraph (3)(B), the term 'qualified beneficiary' includes the covered employee.

"(C) Plan administrator.—The term 'plan administrator' has the meaning given the term 'administrator' by section 3(16)(A) of the Employee Retirement Income Security Act of 1974.". 29 USC 1002

(d) Conforming Amendment.—Paragraph (1) of section 162(i) is amended by striking out "General rule" in the heading thereof and inserting in lieu thereof "Coverage relating to end stage renal disease". 26 USC 162

(e) Effective Dates.— 26 USC 106 note

(1) General rule.—The amendments made by this section shall apply to plan years beginning on or after July 1, 1986.

(2) Special rule for collective bargaining agreements.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) January 1, 1987.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

SEC. 10002. TEMPORARY EXTENSION OF COVERAGE AT GROUP RATES FOR CERTAIN EMPLOYEES AND FAMILY MEMBERS (ERISA AMENDMENTS).

(a) In General.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end thereof the following new part:

"Part 6—Continuation Coverage Under Group Health Plans

"SEC. 601. PLANS MUST PROVIDE CONTINUATION COVERAGE TO CERTAIN INDIVIDUALS. 29 USC 1161

"(a) In General.—The plan sponsor of each group health plan shall provide, in accordance with this part, that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the plan.

"(b) Exception for Certain Plans.—Subsection (a) shall not apply to any group health plan for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar "(i) begins not later than the date on which coverage terminates under the plan by reason of a qualifying event,

"(ii) is of at least 60 days' duration, and

"(iii) ends not earlier than 60 days after the later of—

"(I) the date described in clause (i), or

"(II) in the case of any qualified beneficiary who receives notice under paragraph (6)(D), the date of such notice.

"(B) Effect of election on other beneficiaries.—Except as otherwise specified in an election, any election by a qualified beneficiary described in clause (i)(I) or (ii) of paragraph (7)(B) shall be deemed to include an election of continuation coverage on behalf of any other qualified beneficiary who would lose coverage under the plan by reason of the qualifying event.

"(6) Notice requirements.—In accordance with regulations prescribed by the Secretary—

"(A) the group health plan shall provide, at the time of commencement of coverage under the plan, written notice to each covered employee and spouse of the employee (if any) of the rights provided under this subsection,

"(B) the employer of an employee under a plan must notify the plan administrator of a qualifying event described in subparagraph (A), (B), or (D) of paragraph (3) with respect to such employee within 30 days of the date of the qualifying event,

"(C) each covered employee or qualified beneficiary is responsible for notifying the plan administrator of the occurrence of any qualifying event described in subparagraph (C) or (E) of paragraph (3), and

"(D) the plan administrator shall notify—

"(i) in the case of a qualifying event described in subparagraph (A), (B), or (D) of paragraph (3), any qualified beneficiary with respect to such event, and

"(ii) in the case of a qualifying event described in subparagraph (C) or (E) of paragraph (3) where the covered employee notifies the plan administrator under subparagraph (C), any qualified beneficiary with respect to such event,

of such beneficiary's rights under this subsection.

For purposes of subparagraph (D), any notification shall be made within 14 days of the date on which the plan administrator is notified under subparagraph (B) or (C), whichever is applicable, and any such notification to an individual who is a qualified beneficiary as the spouse of the covered employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time such notification is made.

"(7) Definitions.—For purposes of this subsection—

"(A) Covered employee.—The term 'covered employee' means an individual who is (or was) provided coverage under a group health plan by virtue of the individual's employment or previous employment with an employer

"(B) Qualified beneficiary.—

"(i) In general.—The term 'qualified beneficiary' means, with respect to a covered employee under a group health plan, any other individual who, on the

"(C) The divorce or legal separation of the covered employee from the employee's spouse.

"(D) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act. 42 USC 1395c

"(E) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

"(4) APPLICABLE PREMIUM.—For purposes of this subsection—

"(A) IN GENERAL.—The term 'applicable premium' means, with respect to any period of continuation coverage of qualified beneficiaries, the cost to the plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid by the employer or employee).

"(B) SPECIAL RULE FOR SELF-INSURED PLANS.—To the extent that a plan is a self-insured plan—

"(i) IN GENERAL.—Except as provided in clause (ii), the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to a reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries which—

"(I) is determined on an actuarial basis, and

"(II) takes into account such factors as the Secretary may prescribe in regulations.

"(ii) DETERMINATION ON BASIS OF PAST COST.—If a plan administrator elects to have this clause apply, the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to—

"(I) the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period under subparagraph (C), adjusted by

"(II) the percentage increase or decrease in the implicit price deflator of the gross national product (calculated by the Department of Commerce and published in the Survey of Current Business) for the 12-month period ending on the last day of the sixth month of such preceding determination period.

"(iii) CLAUSE (ii) NOT TO APPLY WHERE SIGNIFICANT CHANGE.—A plan administrator may not elect to have clause (ii) apply in any case in which there is any significant difference, between the determination period and the preceding determination period, in coverage under, or in employees covered by, the plan. The determination under the preceding sentence for any determination period shall be made at the same time as the determination under subparagraph (C).

"(C) DETERMINATION PERIOD.—The determination of any applicable premium shall be made for a period of 12 months and shall be made before the beginning of such period.

"(5) ELECTION.—For purposes of this subsection—

"(A) ELECTION PERIOD.—The term 'election period' means the period which—

June 23, 1986

United States Senate
Committee on Governmental Affairs
c/o Aline Jenuardi, Chief Clerk
Subcommittee on Intergovernmental Relations
432 Hart Senate Office Building
Washington, D.C. 20510

Honorable Senators:

I am writing because my boyfriend has a heart condition. He is a Yellow cab taxi driver (thereby an independent contractor). He had the chance, at one time, to pay into his cab company's health insurance plan but he did not.

He now is 35 years old, uninsurable, and without benefits.

In the past few weeks he has taken off from work entirely to stay at home. I went outside with him once to go to lunch (we wanted to go out together for a special occasion) and he was so tired that afterwards he immediately went back into his house and went to bed. He has lost a lot of money from being ill, and he has no reserve funds to rely on.

I have called different government agencies (he called insurance companies) and I learned that he could get approximately $74 in food stamps and $275 in General Assistance (although he himself would have to go down to the office, which would be extremely stressful). Out of pride, he has refused to go to those agencies. Although money is very tight for us now, I know that every night he goes out to drive his cab he is tearing himself down and endangering his life.

I write this letter in the hope that you pass legislation for "uninsurable" people. Bill has worked hard all his life. Up until a few months ago, he had the record for driving the most miles in his cab than any other cab in the fleet. The company once used his car as the test vehicle for durability because he was the first to break in the 1985 models.

I hope you take these facts into consideration when you debate on insuring "uninsurable" people.

Thank you for your time.

Sincerely,

Maureen McGillen
306 Chenery
San Francisco, CA 94131

P.S. If you can give me any advice, I would greatly appreciate it.